The Functional Basis of Hospital Planning

The Economics of Anesthesiology Service

Have We Over-Educated Our Nurses?

March
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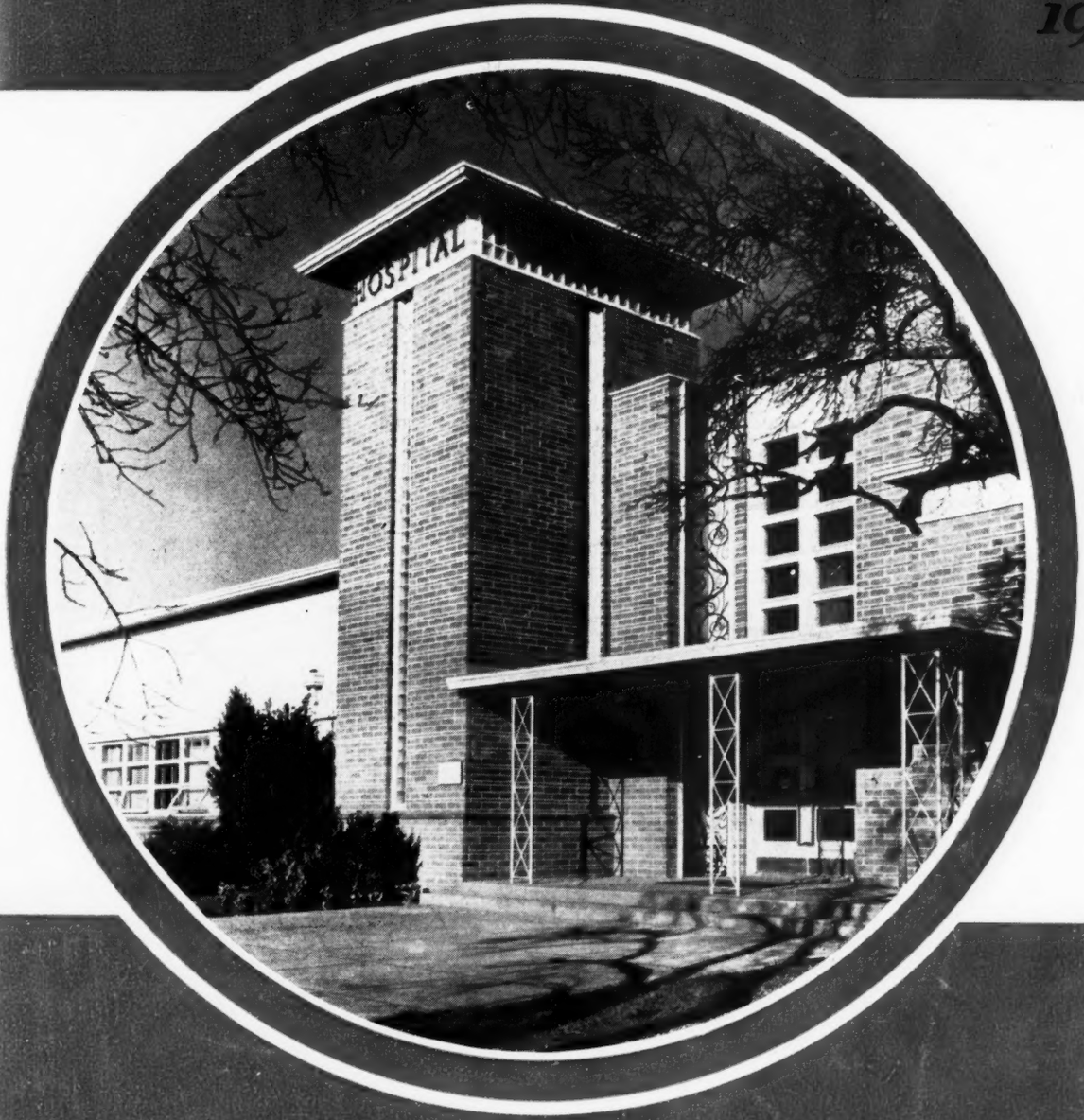
1947



the Modern Hospital

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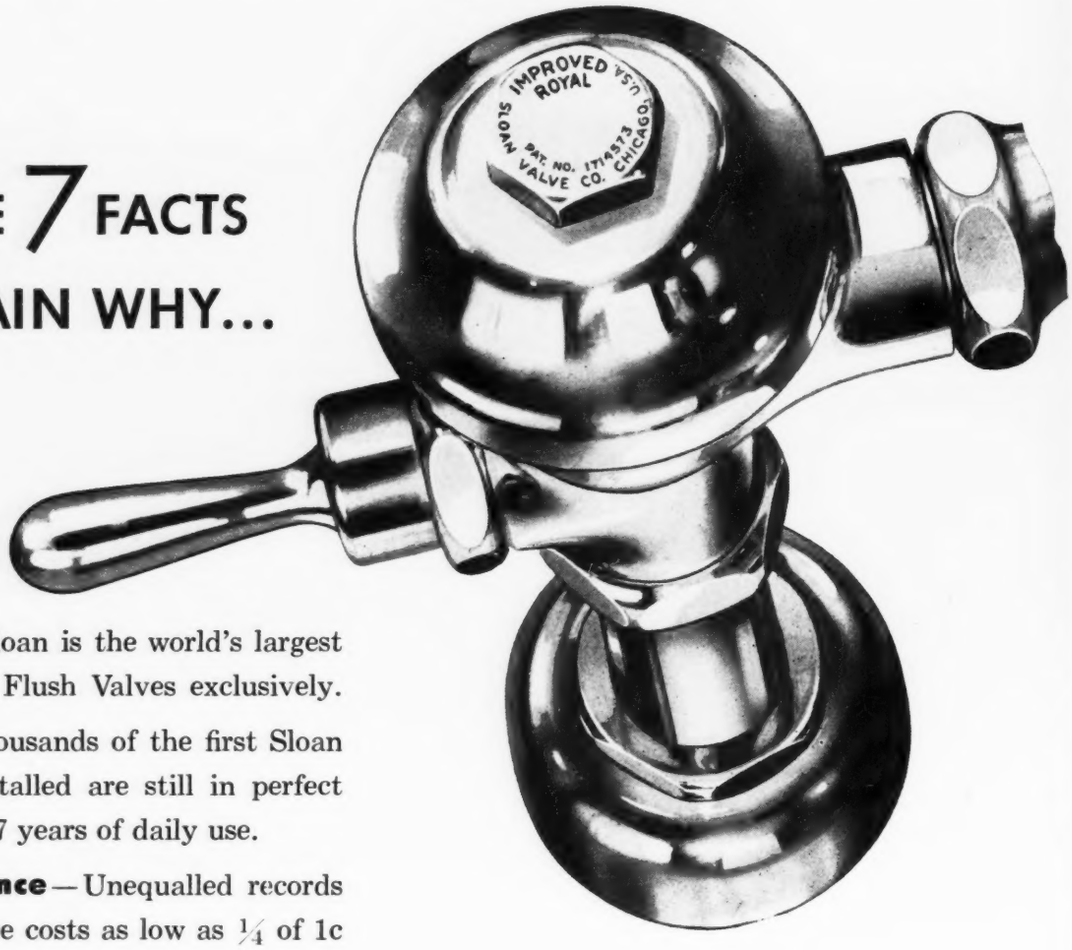

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'BECOTIN WITH VITAMIN C' (Vitamin B Complex with Vitamin C, Lilly) furnishes all the known water-soluble vitamins. In addition to the entire vitamin B complex, this product provides a therapeutic dose of the synthesized B vitamins and ascorbic acid.

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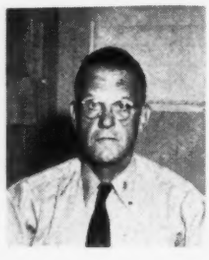
This Month

WE INTRODUCE....

W. Allen Conroy, M.D., is senior attending anesthesiologist and director of anesthesiology at St. Luke's Hospital, Chicago, to which he returned last year after serving as chief of the anesthesia and operating section at the army's Gardiner General Hospital. At 33, Dr. Conroy is also assistant professor of anesthesiology at the University of Illinois. He is a graduate of the University of Alberta's faculty of medicine at Edmonton and received his specialty training at the University of Wisconsin. At St. Luke's, he heads a staff consisting of three fully qualified anesthesiologists, four physicians in training, one intern and three nurses.



Lucius W. Johnson, M.D., has been planning, inspecting or working in hospitals for more than forty years—from the beginning of his internship in Philadelphia's old Blockley Hospital in 1903 to his present duties as a representative of the American College of Surgeons. In his first administrative post, as executive of the U. S. Naval Hospital at Guam, he was responsible for the care of natives as well as marine and navy personnel.

"These *Chamorros* were a light brown, amiable people who were firmly convinced that all *Americanos* were demented," Dr. Johnson relates. "In deference to our crazy ideas, patients would stay in bed until the doctor made his final rounds at night. Then they got out of bed and slept in comfort on the plank floor, just as they did at home. Inasmuch as every patient brought a few members of his family along to wash, feed and guard him while he was in the hospital, there was always plenty of help around to get even the sickest patients in and out of bed.

"When we had to see a patient at night, we would make a lot of noise outside the ward and then wait, so they all had time to get back into bed. This saved everybody's face."

Later, as chief surgeon and administrator of the Haitian General Hospital, Port-au-Prince, Dr. Johnson was in charge of a working group which included French Sisters, a Belgian priest, Haitian doctors and nurses, U. S. Navy doctors and corpsmen and a few Red Cross nurses. "Each group was belligerently race conscious," Dr. Johnson recalled recently. "For three years there was never a dull moment!"

Among other assignments, Dr. Johnson helped develop the navy's mobile hospitals since their earliest days, was senior medical officer of the fleet hospital ship *U.S.S. Relief* and executive officer of the navy's largest hospital, at San Diego, and served a turn in Washington as officer in charge of all hospital construction. To help plan the beautiful new naval medical center at Bethesda, Md., Dr. Johnson toured the United States, visiting some 30 of the nation's greatest hospitals. During World War II, Dr. Johnson achieved the rank of rear admiral, which he held at the time of his retirement from the navy a few months ago. As district medical officer at Pearl Harbor, he had charge of more than 12,000 beds, caring for thousands of wounded sailors and marines from the combat areas.

The navy's system of hospital administration calls for broad shoulders and a thick skin, Dr. Johnson says. "The executive officer is obligated to carry out the policies which the commanding officer dreams up and lays down," he explains. "The executive is the ultimate recipient of the buck, which is passed both upward and downward to him. Whatever mistakes are made, the executive officer is to blame."

After nearly a year as administrative intern at Sydenham Hospital in New York, **Frank B. Adair** recently served for several weeks as the hospital's acting director, pending the appointment of the new chief executive, Dr. Sigmund L. Friedman. Mr. Adair is an alumnus of Morehouse College and has studied at Harvard University. Before going to New York, he was business manager at Dillard University, New Orleans, and production manager and administrative officer at Tuskegee Institute.

Starr Parker, M.E., who has been a frequent contributor to The Modern Hospital in past years, was formerly mechanical director of Christ Hospital at Cincinnati and St. Luke's Hospital, Cleveland. During the war he served as head of the Heating and Refrigeration Section, Utilities Branch, Fourth Service Command, with headquarters in Atlanta, Ga. Later, along with other responsibilities, he was in charge of maintenance and operation of several hospitals at Fort Benning, Ga. Mr. Parker is now mechanical engineer with the H. H. Meyer Packing Company, Cincinnati. He is a member of the American Society of Mechanical Engineers, the National Society of Professional Engineers and the Society for the Advancement of Management. He is also on the faculty of the evening college at the University of Cincinnati as lecturer in mechanical engineering.

THE ROVING REPORTER

It's Blood They're After

"Save a neighbor's life or perhaps your own."

An appeal like this usually means money but not necessarily so at Abington, Pa. Abington Memorial Hospital recently started a new blood typing program for the community. It hopes to uncover all persons with rare blood types so that they can be easily identified in case of accidents requiring blood transfusions and so that if a life is threatened the hospital will know where to turn for an emergency donor.

That the hospital means business in this community service program can be seen by the fact that it supplies speakers for civic, service and other clubs telling them the story of the risk that is involved when an Rh negative individual receives Rh positive blood. The hospital asks club members to come as a body to the hospital for free blood typing.

Individuals, not associated with clubs, also are invited to have their blood typed, without charge, by appointment with the hospital laboratories.

Now many Abington citizens have cards in their bill folds showing their blood type. They know, too, how important it is that an Rh negative girl or woman before or during the child-bearing age should never receive an Rh positive blood transfusion.

Psalms Bring $151,000

Bibliophiles have not been so excited in twenty years as they were recently when at public auction a rare book sold for $151,000 to set the American and perhaps the world's record.

Equal excitement was felt at North Country Community Hospital, Glen Cove, N. Y., for this 100 bed hospital, which serves 20 Long Island communities, is to receive the net proceeds.

Other rare book items auctioned at the Parke-Bernet Galleries, New York City, at the same time brought the total sale to $202,290. The net on this important auction sale will set off to a fine start the hospital's $1,750,000 building fund campaign which is to increase the hospital's capacity to 160 beds and 40 bassinets, to modernize the plant completely and to provide the community with a small medical center.

The book that made history at the sale was the famous Bay Psalm Book printed in Cambridge in 1640, the first work printed in English America that can be called a book and the first that can be seen. It has long ranked among the world's most famous books; only 11 copies are extant and this one is in perfect condition.

This copy was sold by direction of the Gertrude Vanderbilt Whitney Trust for the sole benefit of North Country Community Hospital. A rare book dealer, Dr. A. S. W. Rosenbach, bought it, outbidding Cornelius Vanderbilt Whitney by $1000. It has been in the Whitney family for sixty-eight years.

The Bay Psalm Book is titled "The Whole Booke of Psalmes, faithfully translated into English metre, wherein is prefixed a discourse declaring not only the lawfullness but also the necessity of the heavenly Ordinance of singing Scripture Psalmes in the Churches of God."

Pearl A. Klick is administrator of North Country Community Hospital.

Why let Noise Demons worry a patient?

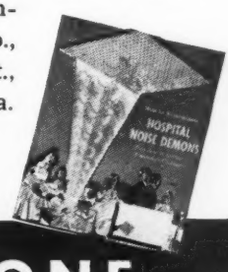
For 3¢ a day you can give her quiet

With a ceiling of Cushiontone

YOU CANNOT COUNT in money what patients suffer in discomfort or delayed convalescence due to noise. But surely it's worth more than 3¢ per bed per day to give them restful quiet. And that's all it costs, when figured over a few years, to install noise-quieting ceilings of Armstrong's Cushiontone.

More than 75% of all the sound that strikes the surface of Cushiontone is absorbed in the 484 drilled holes in each 12" square of this fibrous material. Also, Cushiontone is an excellent reflector of light and can be repainted without loss of acoustical efficiency. Installation can be made over almost any type of ceiling structure.

WRITE FOR FREE BOOKLET, "How to Exterminate Hospital Noise Demons." Armstrong Cork Co., 5703 Stevens St., Lancaster, Penna.



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ARMSTRONG'S CUSHIONTONE

Armstrong Cork Company (A) Lancaster, Pennsylvania

Time Out for Coffee

The cheerful group shown here is toasting Administrator Alden B. Mills of Huntington Memorial Hospital, Pasadena, Calif. Through Mr. Mills' efforts the hospital recently opened a free juice bar. The project started in a small kitchenette but it rapidly grew so popular that it had to be moved to the main dining room. Now any employe is entitled to a free cup of coffee or glass of fruit juice each day between 10 and 10:30 a.m. Participants in the "pause that refreshes" are asked not to let it run over fifteen or twenty minutes and in most instances they don't, Mr. Mills reports. Mrs. Georgie Grady is in charge of the main dining room and may be seen in the photograph. She works under the direction of Elizabeth Gibson, head dietitian.

Loyalty Is the Key Word

Gold or silver service pins are being worn proudly by employes at St. Joseph Hospital, South Bend, Ind. Sister Mary Ellen, Superior of the hospital, designed the pins herself and the word she chose to be inscribed above the coat of arms of the Sisters of the Holy Cross was "Loyalty." Below the blue enamel shield of the Sisterhood is "St. Joseph Hospital."

It may be a sad commentary on the times that those who are entitled to wear the service pin are those who have been satisfactorily employed by the hospital for three years or more.

Professional workers are awarded gold pins; nonprofessional workers, silver pins. Nineteen employes now wear the pins.

The Patient's Story

"Each day when the vacuum cleaner man came into my room he wore a flower in his work jacket just below his good natured, beaming face. A dashing, incongruous, delightful touch, a work jacket and a great big vacuum cleaner with its noisy roar and a flower in the buttonhole, fragile and perishable, amid the imperishable beauty of kindness."

Ruth MacKay, whose "White Collar Girl" is a widely read column in the *Chicago Tribune,* wrote this at the end of an entire column complimenting the cheerfulness of nurses, technicians and other workers at St. Luke's Hospital. Mrs. MacKay was a recent patient.

Every patient does not have that vast an audience but every patient has a fairly wide circle who must listen to his account of his hospital adventures. How telling are the little touches like a white flower on a work coat!

READER OPINION

Appointment Deplored

Sirs:

Your editorial in the January issue under the heading, "Appointment in Chicago," was very good. All that was said is true, but you could have extended yourself.

The same old practice seems to be with us: Appointing an inexperienced and unqualified person to direct the affairs of a hospital. In this instance it is most deplorable because it is one of the largest institutions in the world that calls for strong and able leadership. No defense can be offered by the county commissioners.

Although the American College of Hospital Administrators and able individual administrators everywhere have hoped and labored toward correction of such practice, it is nevertheless still with us. Control really rests with the A.M.A. and the A.C.S., through their approving programs. Until these organizations deny or withdraw their aproval of those hospitals which appoint inexperienced executives to assume institutional direction and leadership, the deplorable situations will continue. Until this is done, there will always be a weak link in the administrative organization of hospitals.

J. Dewey Lutes
Superintendent
Yonkers General Hospital
Yonkers, N. Y.

Job Evaluation

Sirs:

As a result of the interest which has been evidenced in the first of the series of articles on job evaluation and job control ("A New Tool for Personnel Management," by S. S. Preston and Karl H. York, The MODERN HOSPITAL, December 1945), I anticipate not only the same such interest in the subsequent articles but also the desire of many administrators and managers to realize the advantages of the system as applied to their own institutions. I have received several inquiries which support this belief. The administrator of one West Coast hospital has requested that he be furnished with material which will enable him to build the system in his hospital.

This is a source of considerable concern to me. It has been my observation and experience that, as with any system which involves professional and specialized aspects, the layman who attempts to initiate and establish the system invites disappointing failure. I am thoroughly convinced that job evaluation and job control methods must be considered most seriously if we are to administer wage and personnel problems scientifically and with some degree of uniformity, and I would hate to see a few initial failures retard a progressive movement.

What assistance can be given to administrators who desire to analyze and evaluate the jobs within their hospitals and to set up job controls? How can such assistance be given at the time it is needed?

During these last two or three years I have learned to recognize the advantages of reducing job information, job terminology, labor costs and labor standards to some national common denominator. If I chance to discuss my labor and wage problems with the administrator of a Chicago hospital, for instance, I should like to have the assurance that each understands fully the meaning of the terms that are employed by the other.

Unquestionably, we, as administrators, will have to deal with organizations of employes whose policies and demands are formulated on a state or nationwide front, and we will stand in sore need of a means of assembling and correlating information relating to jobs, functions, wages, hours, working conditions and innumerable other matters incident to employment.

Also, there continues to be an increased interest in hospitals and hospital services by local, state and national governmental agencies. Representatives of these agencies are for the greater part accustomed to job classifications and wage scales patterned after Civil Service procedures, and our discussions of jobs and job costs with them would be more intelligent and effective if we had at hand well organized and systematized information. I believe it would be of advantage to hospitals to establish procedures designed to fit the characteristic needs of hospitals, instead of seeking to follow more generalized patterns.

For these and a number of other reasons, I recommend the development of a nationally uniform method of accumulating accurate data relating to hospital jobs and the functional services rendered and invite attention to the merits of such a plan.

Karl H. York
Administrator
Arlington Hospital
Arlington, Va.

SMALL HOSPITAL QUESTIONS

Conducted by Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William B. Sweeney, Windham Community Memorial Hospital, Willimantic, Conn.; A. A. Aita, San Antonio Community Hospital, Upland, Calif.; Pearl Fisher, Thayer Hospital, Waterville, Me., and others.

Librarian May Take History

Question: Is it generally considered good practice to have the record librarian write patients' personal histories, with the doctors giving the results of the clinical examinations? —F.K.S., Wyo.

ANSWER: In a medium or large sized hospital with a competent staff of interns and residents the patient's personal history, as well as the results of the clinical examination, should be done by a doctor. In a smaller hospital that has no interns or residents it is often necessary to have a nurse, admitting officer or record librarian take and write the patient's personal history. Certainly, it is much better to obtain the personal history this way than not to get it at all.—EVERETT W. JONES.

Administrator Should Attend

Question: Is it desirable that the administrator attend the medical staff meetings?—A.L., Mo.

ANSWER: It is my impression that it is not only desirable but necessary that the administrator attend medical staff meetings. Much information of administrative importance can be so gained and by his attendance the administrator also evidences before his staff an interest in its problems.—ROGER W. DEBUSK, M.D.

Medical Assistant Mandatory

Question: What is the responsibility of the administrator of the hospital with reference to doctors doing major surgery with no assistant other than a scrub nurse? How would you deal with the situation?—L.M., Ala.

ANSWER: It is an established principle in all well run hospitals and is a requirement for approval by the American College of Surgeons that doctors who do major surgery must have a qualified medical assistant at all operations.—E. W. JONES.

What About Cream of Tartar?

Question: What procedure is usually followed when cream of tartar is used instead of talcum powder on surgical gloves? Is its use widely accepted? Are there any contraindications?—E.H., Iowa.

ANSWER: Cream of tartar, it has been reported, has a tendency to cake during the sterilization process. Its use is not widely accepted and there have been many arguments as to whether or not there were contraindications to both powder and cream of tartar. One school of thought held that powder was a cause of adhesion formations. However, real evidence to support this view seems lacking.—ROGER W. DEBUSK, M.D.

Business Manager's Salary

Question: What do you think would be the right amount of monthly salary to pay a business manager of a hospital of 29 beds? We do an average of $5500 a month cash business in addition to the items that are not collected at the time. I have worked here now two years and the business has increased 256 per cent in dollars income. I am still expected to work for the salary of two years ago.—H.S., Ida.

ANSWER: The question as to the right amount of monthly salary for business manager of a 30 bed hospital is difficult to answer. One thing can be said with certainty and that is that such a business manager should be paid a salary equal to that paid executives in other lines of business in the area. Because I have no idea what the prevailing salary scale in that part of Idaho is, it would be difficult to give a specific figure.

It would seem that the board of your hospital should evaluate your responsibilities and position in comparison with similar positions in other businesses, and then pay you accordingly.—E. W. JONES.

Staff Appointments

Question: How should the hospital management regulate the extension of privileges to regularly licensed physicians and surgeons who are newcomers in the community?—A.S., N. Y.

ANSWER: A physician or surgeon who is seeking the privileges of the hospital should fill out an application of the type approved and recommended by the American College of Surgeons and submit this application to the hospital administrator. The administrator should, in turn, collect all the information on the physician, such as his standing in medical school, reports from hospitals in which he served internships or residencies and character references, and then submit the entire file to the credentials committee or whatever committee of the staff has been designated to make recommendations to the governing board regarding staff appointments.

The staff, after carefully considering the applicant, should pass its recommendations up to the board of trustees by way of the administrator. The trustees should then make their decision known to the administrator who, in turn, informs the staff and writes on behalf of the board of trustees to the doctor telling him of his appointment.

Too much emphasis cannot be placed on the moral and legal responsibility of the board of trustees and the administrator in seeing to it that doctors are restricted to those activities that they are competent to handle.—E. W. JONES.

Charity Listings

Question: Which, if any, of the following should be included in a charity listing: (a) company cases; (b) Blue Cross cases; (c) E.M.I.C. cases; (d) relief and old age pension cases; (e) A.D.C. cases?—Sr. M.L., Ill.

ANSWER: None of these cases should be included in a charity listing.—ROGER W. DEBUSK, M.D.

Classification of Injuries

Question: Are injuries to be classified alone or under medical or surgical patients? —Sr. M.L., Ill.

ANSWER: Injuries are listed in the discharge analysis of hospital service as traumatic surgery, and in the disease index under the specific type of injury. —MRS. EDNA K. HUFFMAN.

Protect All Patients

Question: If hospitals restrict the activities of a member of the medical staff to certain types of work, should this apply to all types of cases or just to ward patients?—C.H., Minn.

ANSWER: Hospital boards of trustees must accept their legal and moral responsibility for the careful selection of qualified physicians and surgeons for the hospital staff. In cooperation with the chiefs of the various clinical departments or, if the hospital is not departmentalized, with the older and more experienced men on the staff, the board should specify what the privileges of each member of the staff are. Exactly the same regulations should apply to all patients. Why should the ward patients be better protected than are the private patients? In matters of professional practice and standards in the hospital there must be no distinction based on the economic status of the patients.—E. W. JONES.

LOOKING FORWARD

Sing Something Simple

EVERY occupation has its own little conceits of language. In the *patois* of the advertising business, for example, a magazine is always a "book," although the rest of us, including Webster, distinguish between the two. Similarly, lawyers pontificate in terms of *habeas corpus* and *torts,* engineers sing of stresses, snatch-blocks and coefficients, bankers prattle about yields and printers measure everything in ems, or picas.

The terms peculiar to any other calling, however, are baby talk beside the jargon of medicine, whose conventions of language and usage are as rigid as the social customs of a high school sorority. No self respecting physician, for instance, ever had a patient with pneumonia. The patient always has "a pneumonia." A passion for the definite article often denies us possession of our own organs; the doctor never refers to "your heart" or "her stomach." It is "the heart" and "the stomach" and, while there is rarely any confusion about whose heart or stomach is under discussion, the device seems needlessly pointed toward making human beings feel like laboratory animals.

Grammatically, these are harmless eccentricities. At times, however, the convention calls for downright solecisms. This is the case when the surgeon recklessly ignores the distinction between the transitive and intransitive meanings of the verb and "operates a patient." Another favorite is the use of adjectives for nouns; the person with heart disease is a "cardiac."

Most characteristic of all the doctor's linguistic idiosyncrasies, however, is his resolute devotion to the complicated in place of the simple. "It was observed by the writer" is invariably the preferred form in medical papers; "I saw" is too easy. An infection never follows; it "supervenes." Death is the "terminal episode." The windpipe is always the *trachea,* earache is *otitis media* and a cold is *acute coryza.*

Of course, precision in terminology is essential in an exact science. All these words have a specificity of meaning which ordinary descriptive language lacks and which the doctor and his associates require in their work. In medical conferences and consultations, and in the medical journals, the needs of science unquestionably are better served when the doctors make with the Latin. *But they ought to leave it out in the hall when they enter the patient's room!* Apart from the fact that it is plain bad manners to talk over the patient's head, the doctor who uses language that is unintelligible to the layman is often defeating his own ends. Many times, he thus needlessly frightens or confuses a patient whose composure is essential to speedy recovery. It shouldn't happen.

Except in the case of interns and young physicians who are flexing their professional biceps, so to speak, for the benefit of the awed peasants, such offenses result for the most part from thoughtlessness. The doctor is habituated to his own speech and simply never thinks of how it may sound to a layman who is sick and probably a little scared anyway. An occasional reminder from the administrator may be all that is needed; it may save patients and relatives a lot of anguish, and it will help add up to that friendly, personal atmosphere which makes such an important contribution to good hospital care.

(Boy, have this copy set 11 on 12 Granjon, 20 pica lines!)

Architectural Planning

IN THIS issue, The MODERN HOSPITAL presents the first sections of a study on hospital planning prepared by the technical services staff of the Division of Hospital Facilities, U. S. Public Health Service. Here and in succeeding issues, the functions of various hos-

pital departments are analyzed in relation to design, with illustrated flow charts showing principal lines of traffic into the hospital and among and within its chief units.

Resulting from years of study of hospital functions by Marshall Shaffer and his technical staff in the Hospital Facilities Division, this text should help tremendously to prepare the architect for hospital responsibilities. Together with the articles by Dr. Johnson and Mr. Riley in this issue and the regulations prepared by the division staff, it will also serve as a guide to hospital administrators, trustees and consultants who are planning new building or building expansion projects.

If there is a need for architects to be familiar with these important works on hospital planning, there is an equal need for hospital planning groups to make certain that the architectural profession is represented in their councils. Especially, there should be an architect on every state planning authority, to review the design and structural phases of hospital building programs at this level. Effective operation of Public Law 725 toward its ultimate objective, better health for the American people, can be accomplished only by wholehearted teamwork on the part of all interested groups, including public health authorities, the medical profession, hospital administrators, architects and the building industry.

Fighting the Cost Spiral

BREAKING out into sharp exchanges here and there across the country from time to time, the argument about Blue Cross payments to hospitals goes on and on, with many hospitals claiming payments are inadequate to meet today's mounting costs, and plans maintaining that hospital "losses" on Blue Cross are more apparent than real.

Since conditions vary widely from plan to plan and from hospital to hospital within the same plan, it is impossible to generalize on the merits of these arguments. Like the increasingly important problem of payment by government agencies for care of indigent patients, however, the Blue Cross question does underline one consideration: Whether payment comes through Blue Cross, or insurance, or government, or directly from the individual patient, there is a ceiling to the amount that can be paid for hospital care. Probably we are closer to that ceiling today than most of us realize.

With the cost of most items of equipment and supply and labor spiraling upward, the individual hospital appears helpless to struggle against the rising economic tide. Yet it is not certain that every hospital, even today, has done everything that can be done to reduce costs without diminishing quality of care. As wages go up, for example, it is more important than ever for hospitals to make careful job classification studies to make sure that people in comparatively highly paid jobs are not doing work that lower paid people could perform competently. In spite of the desperate nursing shortage, it is a fact that graduate nurses in some hospitals still spend a quarter or a third of their time doing nonprofessional work.

Similarly, economies can be effected in many other hospital departments. Actual experience has shown that adequate drug therapy may be provided by hospital pharmacies stocking 500 or 600 items instead of the commoner, and costlier, 2000 to 5000. Simplification and standardization of purchasing in other departments offer similar opportunities to effect needed savings by eliminating unnecessary multiplication of types, sizes, styles and models ordered. Fuel costs can be lowered by seeking accurate knowledge of fuel efficiency; systematic engineering inspection may reduce plant repair and replacement costs.

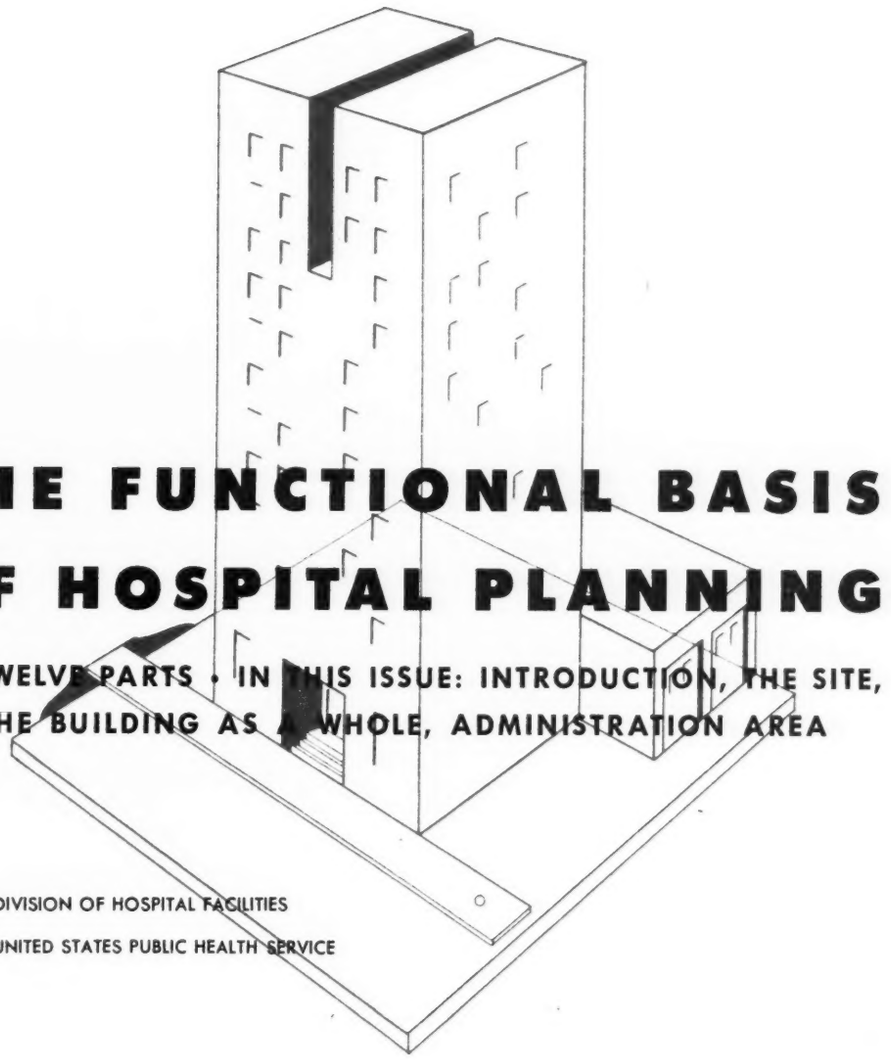
It might be argued that all these measures are aimed at saving pennies in a dollar famine, and possibly there is some truth in this view today. Maybe hospital care, even at the most efficient levels, is going to cost more than people want to pay for it. But the chances are that this isn't so. In the long run, the hospital that can say to Blue Cross, and to government, and to the public, "This is what we have to charge," resting its case with confidence on efficient operation in every aspect, is more likely to find that Blue Cross, and government, and the public will pay its charges. Without arguing.

Departing Employes

WHAT is the state of mind of the departing employe? At first blush this may not seem important. Yet what the employe has to say about what goes on in the hospital can have a definite effect on the institution's good name within the community.

Writing on the subject elsewhere in this issue Norman D. Bailey recommends an exit interview, on the basis that the attitude of the departing employe is of major significance. Not only does his state of mind influence good will within and without the hospital but his observations may be instrumental in effecting changes in management or working routine to rectify existing wrongs.

The procedure as described is simple, effective and well within the scope of every hospital, large or small. The chief requisite is that the administrator cares what goes on in the mind of the departing employe and recognizes that in his withdrawal may be found the answers to certain personnel problems. Particularly in these days, we have reason to explore why workers seek employment elsewhere than in hospitals.



THE FUNCTIONAL BASIS OF HOSPITAL PLANNING

IN TWELVE PARTS • IN THIS ISSUE: INTRODUCTION, THE SITE, THE BUILDING AS A WHOLE, ADMINISTRATION AREA

DIVISION OF HOSPITAL FACILITIES

UNITED STATES PUBLIC HEALTH SERVICE

THE HISTORY OF A SUCCESSFUL HOSPITAL begins long before adequate care is actually available to the sick of a community.

From the initial idea in the mind of an individual to fruition in successful ministration to patients, there must be coordination of thought, planning and activities to produce an institution capable of discharging efficiently its primary and secondary functions. The primary function is, of course, immediate care of the sick patients confined within its walls. Secondary phases, necessary to the success of the first, include adjunct services, proper utilization of employes and facilities, education and research, public goodwill, outpatient service and other general community welfare activities.

The purpose of this text is to assist in the evolution of the tangible phases of physical properties.

In planning either a new hospital or the extension of existing facilities, the governing board of a hospital is faced with the problem of procuring adequate technical guidance in both planning and construction. Unless such guidance is obtained a new structure may fail to embody modern principles of construction and equipment. Similarly, an extension of existing facilities may result in an expanded but poorly integrated institution which cannot discharge its functions economically or efficiently.

It is considered highly desirable in the hospital field to engage two separate and distinct technical services for the purpose of judicious planning: *that of the architect and that of the hospital consultant.*

The architect plans the building and supervises the construction. The consultant acts as the executive representative of the governing body; he confers with and advises the architect on fundamental details of planning which affect the utility of the structure for its highly specialized purposes.

The consultant is also concerned with the furnishings and equipment of the hospital. He assists the governing body in the formulation of such organiza-

tional regulations and administrative procedures as may be required by the board.

The architect should be selected with care and discrimination. He either should have had adequate experience in the planning and construction of hospitals or should be associated with some firm which has had such experience.

It is advisable to have the consultant recommended by one of the national accrediting agencies—that is, the American Hospital Association or the American College of Surgeons.

Each hospital is a problem unto itself. Local factors will have an important influence on the types of patients to be treated, facilities furnished, distribution of services, apportionment of beds and many other details of planning and operation. It is important to have all details of the program set forth in writing as early as possible. These include details of planning and operation.

The consultation services of the Hospital Facilities Division of the U. S. Public Health Service are available for the examination of preliminary plans and proposed administrative methods to determine whether or not they conform to accepted standards and to suggest modifications where indicated. While the Hospital Facilities Division has available for consultation both hospital administrative and architectural services, it is not equipped for, nor will it attempt, the designing, constructing, equipping or administrative planning of individual hospitals. Advice can be given on specific problems, but the actual details of working out the suggestions and fitting them to local conditions must remain with the architects and consultants acquainted with local needs.

SINCE THE HOSPITAL SITE AND ITS CONtours may have an important influence on the planning of the structure, the site must be selected before the preliminary plans can be started. It is of vital importance that the site be selected without prejudice and in accordance with certain fundamental and generally conceded requirements of a general hospital. Minor mistakes in planning may often be corrected, but once an institution is erected in an unsuitable location, the community has no method of correcting the error other than to abandon the whole investment. Certain principles concerning the selection of a hospital site have been formulated. An attempt will be made to enumerate them for the guidance of the governing board.

The task of selecting a suitable site requires the services of one familiar with the function of a hospital, with the character of service the particular institution is to render and with general local medical conditions. It also requires knowledge of local sentiment concerning various neighborhoods and the population trends of the various sections of the community.

The ideal method is to obtain the services of both architect and consultant before the site is selected and to use their joint knowledge of requirements as a guide in selecting the most suitable location.

The points to be considered in the selection of a hospital site follow:

1. ACCESSIBILITY

THE ACCESSIBILITY OF THE SITE for ambulant and nonambulant patients, visitors, staff members and personnel and for the delivery of supplies must be considered. The modern hospital designed to handle acute cases should be reasonably accessible to the center of community activity but located in an uncongested district so that unnecessary noise and parking and traffic problems can be avoided.

Although it is best to have the hospital situated so that it can be reached easily from the industrial area of the community, it should not be located too close to industries. Inexpensive transportation facilities for ambulant patients should be available within reasonable distance, especially if an outpatient service is to be maintained. However, these facilities should not be so close to the hospital that their noise would disturb bed patients.

Consideration must be given to visitors and others coming to the hospital by automobile, and first class

roads should connect the hospital directly with local traffic arteries. Direct improved road connections facilitate the transportation of incoming supplies.

2. PUBLIC UTILITIES

THE HOSPITAL should be situated near adequate sewerage, water, electrical, telephone and gas facilities. If these utilities are distant from the site, the expense of installing extensions and connections may be excessive.

Whenever possible the hospital should be served with water from an approved public water supply system. The site should be readily available to a portion of the distribution system having mains of adequate size to furnish the quantity of water that will be required. Water pressure adequate at maximum demand to supply the upper floors of the institution without recourse to booster pumps is preferable, otherwise provision must be made for adequate pressure and quantity at all times, through the use of either booster pumps or elevated storage or both. If a booster pump is used, care must be taken that the capacity of the pump does not exceed the capacity of the line supplying the pump to avoid the creation of a below-atmospheric pressure in the line. While the quantity of water used in a hospital will vary within wide limits, an average figure for the amount of water used may be taken as 200 gallons per bed per day. However, the supply should be adequate to furnish twice this amount on a maximum day.

If the location is such that a private water supply must be developed, available ground water or other source of water requires complete and careful study. The chemical and bacteriological quality as well as the quantity available must be considered. In this type of installation a supply that will be satisfactory with no treatment is highly desirable. A competent sanitary engineer should be retained to advise on the sanitary features of the installation and the plans should be approved by the state health department. The "Public Health Service Drinking Water Standards," the "Sanitation Manual for Public Ground Water Supplies" and the "Report of the Joint Committee on Rural Water Supply Sanitation" are suggested as guides to those concerned with such a development.

Sewer levels should be low enough for adequate drainage of the lowest floor level of the building so that the expense of constant operation of ejectors can be avoided. If ejectors are required, a type that is flyproof and verminproof is necessary.

When connection to a municipal sewerage system is not practical, facilities must be provided for adequate treatment and disposal of sewage. Here, again, a competent sanitary engineer should be retained to advise on the type and degree of treatment to be used to design the installation. The plans for all new sewage treatment plants or for revision of existing plants should be submitted to the state health department for review and approval.

In addition to an adequate water supply with sufficient pressure, fire fighting facilities should be available in the immediate vicinity. It is also preferable that the site be located in an area enjoying police protection. Streets leading to the hospital require sidewalks and adequate lighting. Hard surface roads should adjoin the institution on at least one side, and preferably on two.

3. NUISANCES

THE SITE chosen for the hospital should be free from undue noise, such as that emanating from railroads, freight yards, main traffic arteries, schools and children's playgrounds. It should be remote from industrial or topographical conditions which would encourage breeding of flies, mosquitoes or other insects. The site should not be exposed to smoke, foul odors or dust, or so located that prevailing winds from a nearby industrial development will bring smoke or objectionable odors to the hospital. Proximity to a cemetery is undesirable for a hospital site. Exposure of the building to adjacent fire hazards is to be considered with these other factors.

Not only must such nuisances be avoided at the time of construction but consideration should also be given to any probable future developments of an objectionable nature in the immediate area.

4. ORIENTATION AND EXPOSURE

THE SITE SHOULD BE CHOSEN with consideration for proper orientation of the structure so that every patient room will receive sunlight at least during part of the day and proper advantage can be taken of prevailing winds in the interest of natural ventilation. The most advantageous orientation will vary in different latitudes and in different sections of the country, but normally the areas occupied by patients in the north Temperate Zone should face the south, southeast or southwest.

An ideal site in northern latitudes would permit the placing of the administrative offices, the outpatient department and the service departments on the northerly and street side of the property and the nursing areas on the southerly and quiet side of the property facing sites which do not promise future encroachment.

5. COST

THE INITIAL COST of the site naturally is important, but the total cost, including the expenditures required to make the site suitable for a hospital structure, must be considered. A plot offered as a donation may, in the final analysis, be more costly than is another apparently high priced plot.

Foundations, subsoil conditions, grading, drainage, landscaping, title clearance, proximity of utilities and future maintenance all have bearing on the final cost of the plot. In a small community the cost of land on the outskirts of the town may be quite low and the land may, nevertheless, be accessible and have other advantages. In a larger community the outlying districts may be so inaccessible that the institution must be located nearer to the center of population, and therefore on more costly land.

6. DIMENSIONS

THE MINIMUM SIZE of a plot for a multistory 50 bed hospital probably should not be less than 300 by 300 feet if adequate provision for expansion is to be made. In any case, the plot chosen should allow for future expansion of at least 100 per cent in building area and still retain attractive grounds and obviate objectionable appearances of overcrowding.

Thought may be given to the possibility of subsequent provision for communicable disease, psychiatry and other special services. On the other hand, too large a plot results in costly upkeep. Recreation areas are not required for patients of general hospitals, but some provision is necessary for tennis courts and other recreational facilities if nurses or interns are to be housed.

Sufficient space must be available to accommodate the various traffic lines coming to the institution and ample parking areas must be provided. Some cities, such as Los Angeles, require parking space for one automobile for every two patients. The new hospital, if at all possible, should be built at some distance back from the sidewalk line. Within limits, the farther back the building is located, the better.

7. TOPOGRAPHY

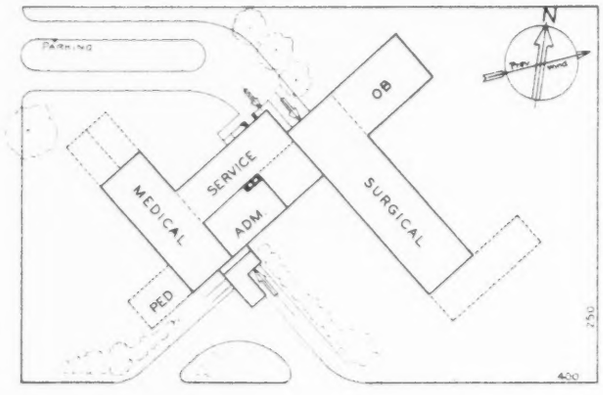
IDEALLY THE BUILDING is best located on relatively high ground in order to take advantage of natural drainage. The elevation should not be so great, however, as to be a handicap to ambulant patients who approach on foot. The plot should be such that it will permit the patient entrances to be close to ground level. A slope toward the rear, so that the natural grade will permit basement service entrances to be at grade level, will be of considerable advantage.

Subsoil conditions must be investigated to determine drainage and soil-bearing properties and whether difficulties in excavation may be encountered. The outlook from the site should be as unrestricted and pleasing as possible. The nature of the adjacent areas should be considered. Location opposite a public park, provided the park is not noisy, is advantageous since it insures against future encroachment of unsightly buildings from that direction.

8. LANDSCAPING

THE PSYCHOLOGICAL EFFECT of attractive grounds on patient welfare, public good will and staff morale cannot be overestimated.

Land area dimensions, topography, orientation and many other factors related to landscaping make it almost imperative that the matter be placed in the hands of an experienced landscape architect who is familiar with local soil, weather and plant life. Services of such an individual should be available from the beginning to cooperate with the architect in assuring the most efficient and attractive ground plans. Beauty and maintenance costs will be directly affected by care in preliminary planning. Common faults in amateur landscaping often occur through overplanning, too close planting, failure to know soil and drainage conditions and lack of utilization of attractive materials indigenous to the area.



THE HOSPITAL BUILDING

IT IS OF UTMOST IMPORTANCE TO REMEMber that a hospital is more than just a building with bedrooms. It is a complicated, highly specialized functional structure which must be designed for the various facilities, instead of having the facilities forced into certain areas because of a desire to produce some particular architectural appearance. Such errors result in nothing but regrets and censure of the planners and builders, with dissatisfied patients, staff and employes and excessive operating or remodeling costs. It is imperative, therefore, that the architect be familiar with hospital functions and that the responsible committee should not arbitrarily specify in advance the exact type or shape of the structure in a manner that handicaps the designer.

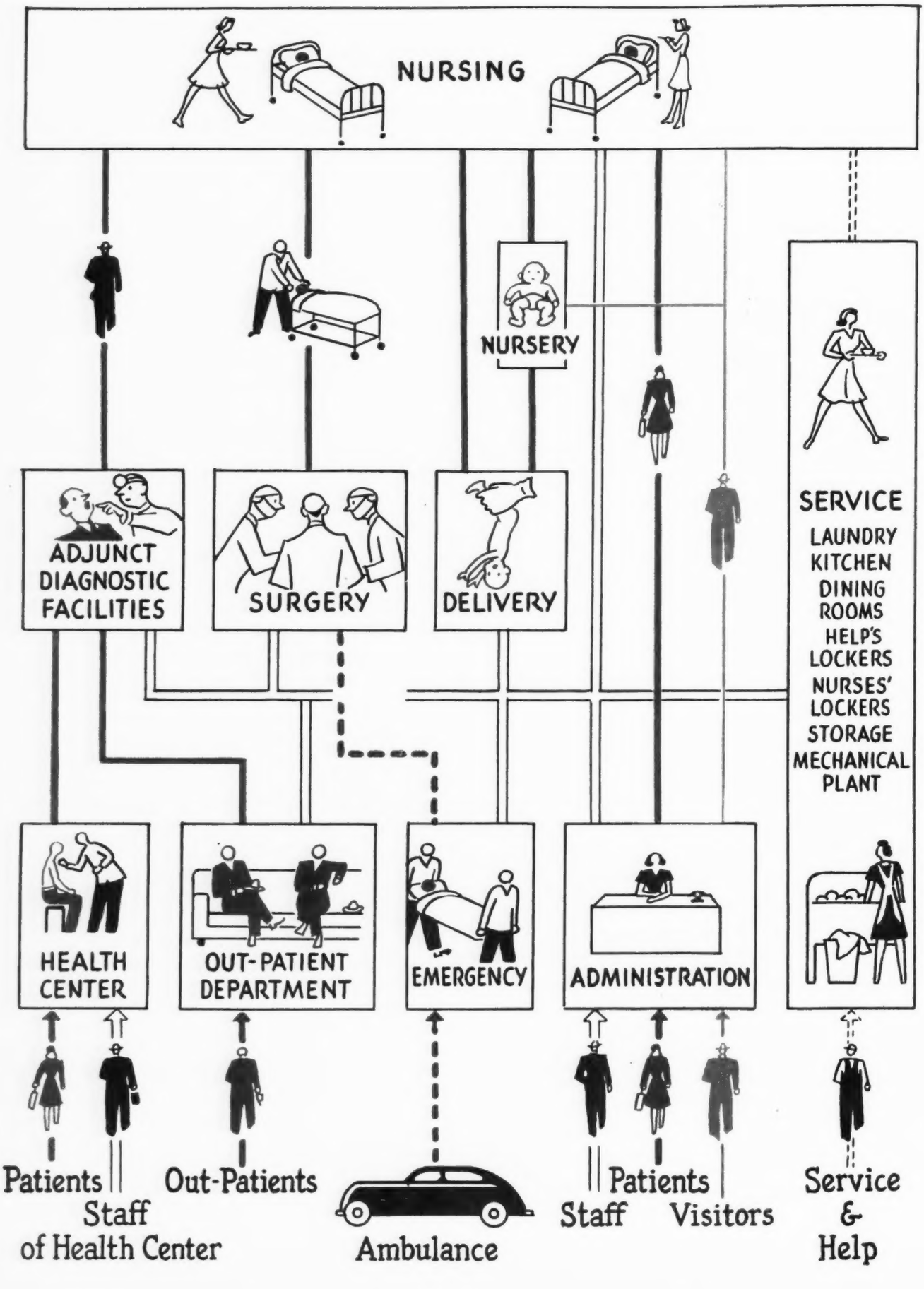
Once the type and size of the institution are determined and the site is selected, the architect and consultant can embark on the actual preparation of the plans and specifications for the building. Decisions as to what facilities and services are to be supplied in the hospital will have to be made by the board of trustees and the hospital consultant, guided by the medical advisory council.

It is advantageous to have a building committee from the board of trustees (to include the administrator if he has been appointed). This committee must be vested with authority to decide on questions of planning detail and report regularly to the board. There is much to be said in favor of retaining the administrator of the hospital early in the procedure, so that he may be thoroughly familiar with the plan and the reasons for its various features.

Once the board and its technical advisers have determined the facilities that will be required and the policies to be followed, it becomes necessary to translate these general principles into a building design. The design should lend itself to proficiency of service and be adequate in its provisions for patients, flexible in its relationship to fluctuating demands, economical in cost of construction, operation and maintenance, architecturally attractive without sacrifice of function and acceptable to the community of which it is a part. Fundamental requirements will include proper orientation of patient accommodations with regard to air, sunlight and quiet, and planning for economical and efficient operation and maintenance.

The present trend in design is toward a compact, multistoried plan, inasmuch as such a structure is less expensive to build, operate and maintain. There are numerous advantages in a single story plan for the small hospital of less than 100 beds, although local factors may make this impractical. Whatever the plan, provision for future expansion demands thoughtful consideration. The construction of the building should be as fire resistant as is possible.

As a guide for the allocation of areas to the various functions and services in the hospital, the Hospital Facilities Division has prepared area allocation charts which are included in full in a following section. In considering the areas shown in these tables, it must be borne in mind that while the areas listed represent acceptable practice and are based on general experience, conditions in specific institutions vary and


NURSING
NURSERY
ADJUNCT DIAGNOSTIC FACILITIES
SURGERY
DELIVERY
SERVICE
LAUNDRY
KITCHEN
DINING ROOMS
HELP'S LOCKERS
NURSES' LOCKERS
STORAGE
MECHANICAL PLANT
HEALTH CENTER
OUT-PATIENT DEPARTMENT
EMERGENCY
ADMINISTRATION
Patients
Staff of Health Center
Out-Patients
Ambulance
Patients
Staff
Visitors
Service & Help

OPPOSITE PAGE: Flow chart shows principal lines of traffic moving into hospital and through various hospital departments

hence the areas specified may be varied within reasonable limits.

Areas often must be adjusted to the depth of the bay and may often be reduced if some novel engineering arrangement is devised. It is to be noted particularly that the area distribution charts do not include provision for outpatient services or health center facilities, these being regarded as entirely separate from the areas for the inpatient services supplied by the hospital. If an outpatient service or health center is contemplated, its areas must be added to those of the hospital proper. The percentage areas given in the charts apply only to that portion of the building devoted to inpatient service.

Space for certain functions will be required in all general hospitals, namely, administrative, service, patient, operating suite, obstetrical suite, laboratory, radiology and emergency room areas. A drug room will also be required. It may be extremely modest with regard to space and equipment or it may include provisions for compounding and manufacturing.

There is a growing demand for physical therapy departments in hospitals of all sizes. The amount of space and equipment to be devoted to such a unit must be determined from local needs and clinical practices. An outpatient department may or may not be indicated, although most hospitals find that sooner or later such services are necessary if they are to fulfill their complete community responsibility. There may or may not be provisions for communicable disease treatment or psychiatry.

A health center containing space for clinics, offices for health officers, sanitary engineers and public health nurses and possibly offices for private physicians and dentists may or may not be included. It is highly desirable to promote coordination of health activities.

Today's trend is to make the hospital the real health center of the community. Because of the many possible variations in the needs of individual communities, and in the individual specialists available for the staff and hence of specialties to be represented, it is difficult to designate exact requirements that would be applicable to more than one specific hospital. Nevertheless, the broad requirements of the average small hospital can be outlined with reasonable definiteness and will be discussed in detail.

Throughout this text attention has been called to the sanitary aspects involved in the construction of a hospital and in hospital equipment. Due consideration should be given these factors in designing the building and specifying equipment. Because of the nature of the institution, the inhabitants of a hospital are, for the most part, in a weakened condition and unusually susceptible to infection. Therefore, every possible safeguard must be incorporated in the design to reduce the possibility of cross infection.

TRAFFIC—EXTERIOR

THROUGHOUT THE PLANNING of the hospital, traffic requires careful thought. Besides the various complicated lines of traffic within the hospital, traffic to and from the hospital must be given consideration.

Exterior traffic includes: (1) patients arriving or leaving by automobile or ambulance; (2) patients arriving or leaving on foot; (3) the visiting public, which should have adequate parking space; (4) staff members, who should have a convenient parking area reserved for their exclusive use, if practicable; (5) controlled ingress and egress of employes, with proper facilities for parking; (6) delivery of incoming supplies; (7) removal of the dead in an unobtrusive manner; (8) delivery of fuel and removal of refuse and ashes if coal is used; (9) outpatient traffic if a clinic or health center is contemplated.

In designing traffic lines to and from the building, conflicting or crossing traffic streams should be avoided. In order to take care of these traffic lines, certain entrances must be provided. The main entrance in most hospitals will receive ambulant inpatients arriving on foot or by car; physicians, provided that their reserved parking area is convenient to that entrance and that their locker room is properly located, and visitors.

An emergency entrance, designed to permit nonambulatory patients to be received from automobiles and ambulances, will be required. This entrance should lead directly to the emergency suite.

A third entrance with proper facilities for unloading will be needed for supplies and should be in close proximity to storage areas, elevators and kitchen refrigerators. It may also be used for removal of refuse. Nonprofessional employes of small hospitals may use this entrance if it is adequately controlled, but in larger hospitals a separate entrance for such employes is generally provided.

Usually, a fourth entrance is provided for the removal of bodies. This entrance should be kept locked unless it is also to be used as the employe entrance. There should, however, be only one entrance for nonprofessional employes. The locker rooms, as well as the employe time and attendance control system, should be convenient to this entrance.

Special provision is necessary for the receipt of fuel and removal of ashes. Finally, if there is an outpatient department, a separate entrance must be provided. In small hospitals it is not considered necessary to furnish more than one outpatient entrance, as separation of different groups of patients may be

on a schedule basis, with different days or hours assigned to various patient groups. In general, the number of hospital exits or entrances should always be held to a minimum, especially if they are to be unsupervised.

INTERIOR

WITHIN THE HOSPITAL are other complicated traffic lines to consider. Here some crossing of traffic streams is inevitable. Orderly internal traffic is facilitated by correctly relating facilities and services.

The main traffic streams are: (1) incoming patients who must proceed from the admitting and social service departments to the patient areas, emergency room, x-ray department or other services; (2) outgoing patients who leave the hospital, usually by way of the business office or the social service department; (3) interdepartmental patient traffic; (4) deceased patients who must be taken direct to the mortuary in as unobtrusive a manner as possible; (5) visitors, who should be under surveillance to and from patient areas and during their entire stay in the hospital; (6) staff members, who ought to be routed past the record library and the physicians' in-and-out board; (7) outpatients, if any, who may be routed to the laboratory, pharmacy, x-ray, physical therapy units or other services in the hospital area proper; (8) employes, who must be routed past their time control station and locker rooms before being allowed in the hospital proper; (9) supplies, foods and wastes, which must be as completely separated as possible from all patient and visitor traffic.

No rigid suggestions can be given for isolating these various streams of traffic within the hospital, but they must be kept under constant consideration in laying out areas. It will be one of the functions of the hospital consultant to suggest the location of the various services and areas in relation to one another and thus minimize the confusion engendered by crossing traffic. As the various services and areas are discussed in detail in this text, suggestions will be advanced for their most advantageous locations.

CIRCULATION SPACE

THE AREA REQUIRED FOR CIRCULATION space will vary widely with the type of building and the number of stories. Figures suggested for the areas of corridors, stairways and elevators in the accompanying area distribution charts are based on buildings of two stories and basement for 50 bed hospitals, three stories and basement for 100 and 150 bed hospitals and four stories and basement for 200 bed hospitals.

CORRIDORS

CORRIDORS throughout the hospital should have a minimum width of 7 feet 6 inches, and preferably 8 feet. They require acoustical treatment. Wall finish should be smooth and washable and finished in light attractive colors. Finished ceiling height will be the same as in other areas, 9½ feet being desirable, although an acceptable method of cooling or ventilation can be obtained by slightly lower suspended corridor ceilings, with louvers opening into rooms. Conditioned air can thus be supplied or exhausted by means of an attic fan. In the main kitchen and laundry, 12 foot ceilings are considered minimum.

Knee or elbow controlled lavatories have been recommended to be recessed in the corridor of each nursing unit to encourage aseptic technic. Drinking fountains are not provided because of the possibility of infection. Provision for paper cup dispensers is much more acceptable at coolers or lavatories located elsewhere than in corridors. An adequate number of fire extinguishers should be recessed in the corridor walls.

Lighting should be by ceiling fixtures. Indirect, fluorescent or cold-quartz lighting should receive serious consideration and study. Night lights and electrical outlets for mobile x-ray work and for cleaning machinery should be installed at convenient places. Easily visible electric clocks should be installed. Call system installations should be provided as required.

. Because vacuum outlets or machinery will be required in operating rooms and laboratories, consideration may be given to the installation of master vacuum pumps in the mechanical section to supply ducts opening into corridors as well. This facilitates cleaning and, although the original cost may appear

excessive, maintenance probably would not exceed that of multiple machines.

Where ramps are required, as in connecting new and old buildings or at the ambulance entrance, the slope should not exceed 5 per cent. Exits should be marked with electric signs.

STAIRWAYS

THE NUMBER AND LOCATION OF STAIRWAYS are usually determined by local ordinance, with due consideration for traffic demands. Many states require hospitals having more than 100 patients on a floor area of 2500 square feet to have at least two continuous runs of stairs. Completely enclosed fire stairs are preferable, whether or not they are required by local ordinance. They should be at least 3 feet 8 inches wide to permit the carrying of stretchers, with special caution to ensure sufficient width at the turns. Standard treads and risers, without winders, are used. It has been found desirable to use either terrazzo treads with incorporated abrasive, or linoleum or rubber treads with metal nosings and abrasive insets.

Hand rails on both sides, continuous from top to bottom, are highly desirable so that it is unnecessary to lift the hand over a gap or newel in assisting a patient. Railings should be a minimum of 34 inches high for safety. Doors to stairs of self closing kalamein with lighted "exit" signs above are necessary.

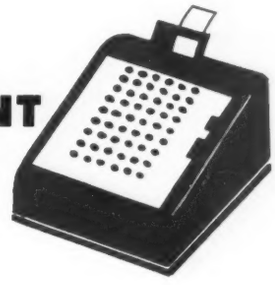
ELEVATORS

IN THE GROUPING OF ELEVATORS it is preferable to have them adjacent to each other rather than widely separated. If more than two elevators are provided the separation of service and passenger types is desirable. Elevators should have a minimum size of 5½ feet by 8 feet in order to take a bed or stretcher with attendants and should be equipped with dual controls, self leveling devices and all safety features. It is advisable to install a telephone in each elevator for emergency purposes.

Elevators need acoustical treatment and resilient floor surface material. Doors should have an opening of not less than 3 feet 8 inches. Office building and apartment house doors are not satisfactory for hospital usage. It is advisable that elevators do not open directly on a nursing corridor.

In larger hospitals one car may be designed with doors at both ends so that it can be used from a service corridor during certain hours and for passengers at other times of the day. In locating elevators, special consideration should be given to the flow of traffic. Multistory hospitals up to 125 beds will require a minimum of two elevators and those up to 200 beds, three elevators. Penthouses should be heated and ventilated because extreme temperature changes interfere with the operation of magnetic switches.

ADMINISTRATION DEPARTMENT



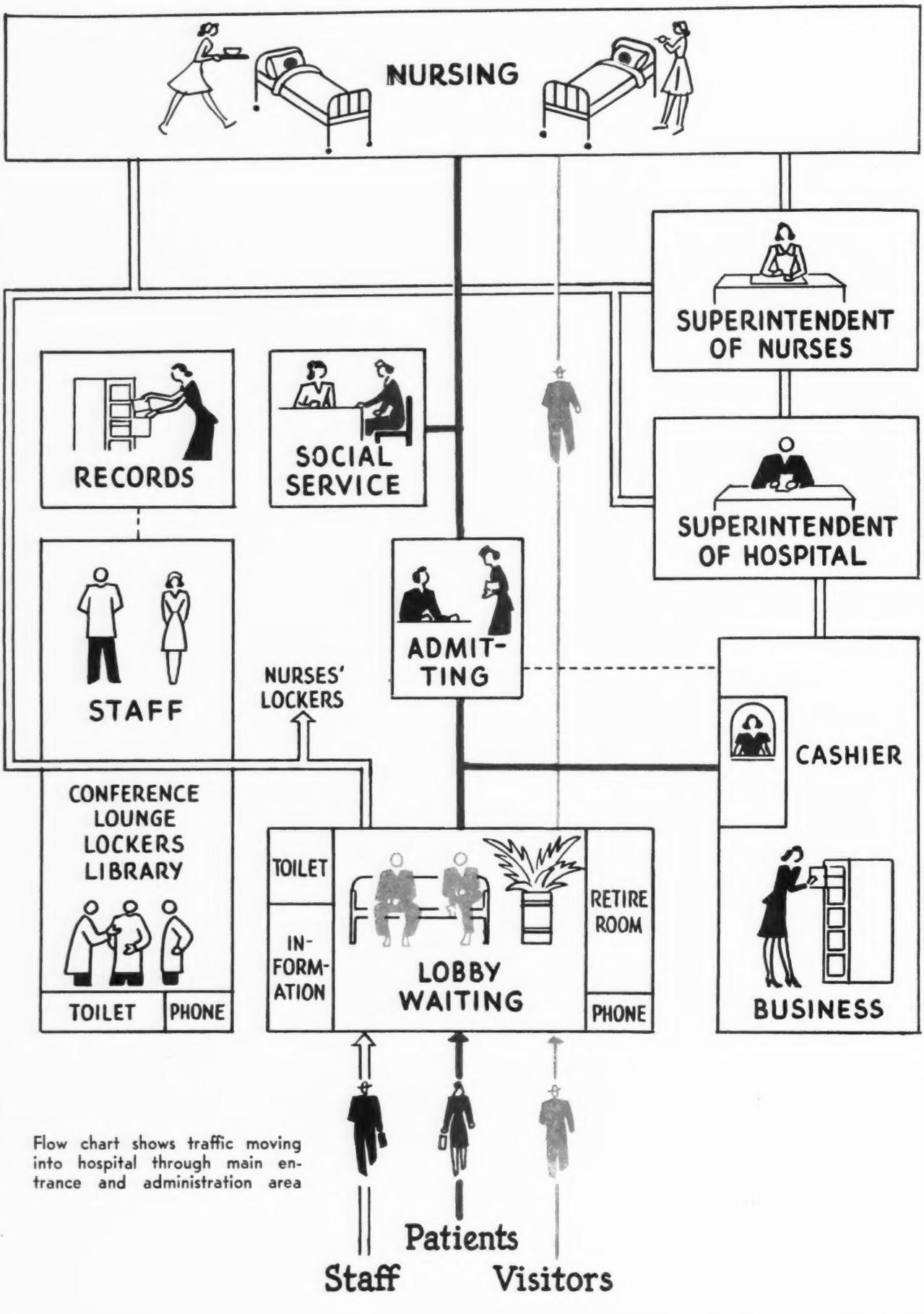
THE ADMINISTRATIVE OFFICES ARE grouped in the area adjoining the main lobby and main entrance. Certain subgroupings should be considered so that each unit within a subgroup will be conveniently located with reference to others. For example, the administrator's office, the director of nurses' office, the general business offices, the secretary's office and the toilet facilities for the administrative staff form one subgroup of the administrative facilities, each unit of which should be convenient to every other unit.

Other subgroups include: the main lobby and waiting room, the information desk, the cashier's window alcove and the public toilets; the admitting office and the social service office; the medical record room and that section of the staff room intended for the record study, and the staff room, locker room, library and conference or board room.

MAIN LOBBY AND WAITING ROOM

THE MAIN LOBBY AND WAITING ROOM should be convenient to the stairs, corridors and elevators leading to the patient areas, but access to these facilities by the public is controlled from the information desk. The lobby and waiting room require adequate space for seating facilities. For sanitary reasons, drinking fountains are not provided, but paper cup dispensers are placed at coolers in the public washrooms.

The lobby should have direct access to the business office through the cashier's window and access to the



Flow chart shows traffic moving into hospital through main entrance and administration area

administrator's office under the control of the information desk. A small retiring room off the main lobby is desirable for anxious or bereaved relatives.

PUBLIC TOILETS. Separate toilets for men and women should be convenient to the lobby and waiting room and, preferably, so located that visitors do not have to go beyond the area controlled by the information desk to reach them. A single toilet in each toilet room will be sufficient except in hospitals larger than 200 beds, in which case two toilets will be required.

PUBLIC TELEPHONE. A public telephone, preferably in a booth, is provided in the lobby of smaller hospitals. In larger hospitals two booths will be required.

INFORMATION DESK AND TELEPHONE SWITCHBOARD

THE INFORMATION DESK is located so as to govern public entry to the hospital proper and to the administrative offices. In small hospitals the telephone and information desk may be combined.

In larger hospitals it is highly desirable to separate telephone and paging service and to restrict the employe's duties, during the day at least, to these communication services. It is often possible to locate the switchboard so that it is separated in the busy hours of the day but can be made to serve as the information desk at night by means of a wicket which can be opened. In hospitals where the information desk and switchboard are not separated, it is advisable to arrange them so as to permit two employes to function during visiting hours. The information desk should be furnished with the standard information equipment, including the doctors' in-and-out register, the patients' index and the room register.

The intercommunicating telephone system should connect all work areas and may be entirely automatic. The system also serves as a general fire signal. The paging control equipment will be adjacent to the switchboard. Although short wave radio may offer an improvement in the future, at present there are three types of such equipment, each of which has its advocates.

Lights have the distinct advantage of silence but are objectionable because they cannot be seen from every point at which the professional staff or employes will be located. The voice annunciator eliminates this objection and for that reason appears to be preferable. However, it must be properly adjusted to eliminate raucous noise. Probably the most economical and efficient of the three types is the automatic system which is combined with the intercommunicating telephone switchboard and signals by soft chimes. Its only objectionable feature is that if the chimes are not adjusted to the proper low tone, it is irritating to patients. It can be adjusted to a decibel rating which is not annoying and yet penetrates to rooms and work areas. Inasmuch as this system is entirely automatic, the announcer is eliminated. Certain numbers of chimes, allocated to various members of the staff and employes, are sounded from any telephone and can be answered from any telephone. This system, like the others, should be zoned so that, for example, the obstetrical nurse will be paged in her work or dining area, but not in the laundry.

The central radio control panel will also be located in the vicinity of the switchboard. Such a system is almost a necessity in the hospital today and the building should be wired for antennae and ground. Distribution circuits will be included in the nurses' call outlets at the patients' bedsides, where the under-pillow type of rubber encased listening devices can be connected. No loud-speakers are indicated unless in the kitchen, laundry or other employe work areas for convenience and reception of announcements, but only if the sound will not be disturbing to patients. The central radio panel permits choice of programs, records, announcements and control of hours of operation.

ADMITTING OFFICE

THE ADMITTING OFFICE should be in a quiet location convenient to the main lobby and, preferably, adjacent to the social service office, if one is provided. In the smallest hospitals, in which the same individual may perform both admitting and social service work, one office is sufficient. In larger hospitals a separate waiting room for these offices is desirable.

No examination facilities are required in conjunction with the admitting room because it is assumed that private patients will have been examined by the referring physician and that other patients will have been examined in the outpatient department or the emergency room. Convenient communication with the business and administrative offices and the emergency room and easy access to the medical record room are required.

BUSINESS OFFICE

THESE PROVIDE the general office space for the clerical staff and equipment, a vault for business records and a safe for patients' valuables. The business office should be arranged with a cashier's window opening from an alcove off the main lobby, but with no direct entry from that area. In larger hospitals it may be desirable to furnish a small private office for some members of the business staff, such as personnel director, auditor, purchasing agent, credit manager and others, but in the small hospital a single room may suffice.

ADMINISTRATOR'S OFFICE

THE ADMINISTRATOR'S OFFICE should be accessible to all other offices but located so as to allow privacy. This is usually accomplished by having the approach through the secretary's office, which also serves as a waiting room.

SECRETARY'S OFFICE. This room may be small, and preferably located so as to serve as an entry and waiting room for the administrator's office. (In larger hospitals offices must also be provided for one or more assistant administrators.)

DIRECTOR OF NURSES' OFFICE

THE DIRECTOR OF NURSES is provided with office space convenient to the administrator's office and to stairs and elevators. The office should be quiet and protected from the public. In larger hospitals space is provided for assistants and a secretary.

SOCIAL SERVICE OFFICE

IN HOSPITALS OF 100 OR MORE BEDS, a separate office for the social service workers is usually required. This should be convenient to the admitting office and reasonably accessible to the business and administrative offices and medical record room. When there is more than one social worker, provisions for privacy in interviewing must be arranged. If an outpatient department is contemplated, the social service office should be readily accessible from the outpatient waiting room. In larger hospitals a special office for social service interviewing may be furnished in the outpatient section.

MEDICAL RECORD ROOM

THE MEDICAL RECORD ROOM should be accessible from the admitting office and the outpatient department. It may well adjoin and control the entrance to the staff locker room and should have convenient access to the inactive record storage room below, possibly by a spiral staircase. Space should be available either in the record room or in the staff room for staff members to use while completing their medical records and for reviewing microfilmed records if that system is contemplated. In larger hospitals it may be necessary to provide a pneumatic tube or other device to convey records to and from the nurses' stations, admitting room, outpatient department and emergency room.

LIBRARY AND CONFERENCE ROOM

IN THE LARGER HOSPITALS a separate library and conference room should be provided. It is advantageous if this can adjoin the medical record room, thus serving the double purpose of furnishing a control for the library books and space for staff members to consult records without removing them from the control of the medical record librarian.

The library should have adequate shelving and provisions for unbound periodicals. In smaller hospitals a combination board room, staff conference room and medical library may be arranged in conjunction with the administrator's office by the use of accordion doors, thus enabling the total space to be made available for large meetings. If part of this space is used for a library, built-in shelves should be provided; if it is used for the conference room, a screen and equipment for exhibition of moving pictures and two built-in x-ray view boxes should be installed.

Library space is required if interns are to be trained in the hospital. If it is not furnished as suggested, it should be provided for in the staff lounge or in a record study adjacent to the record library.

STAFF LOUNGE AND LOCKER ROOM

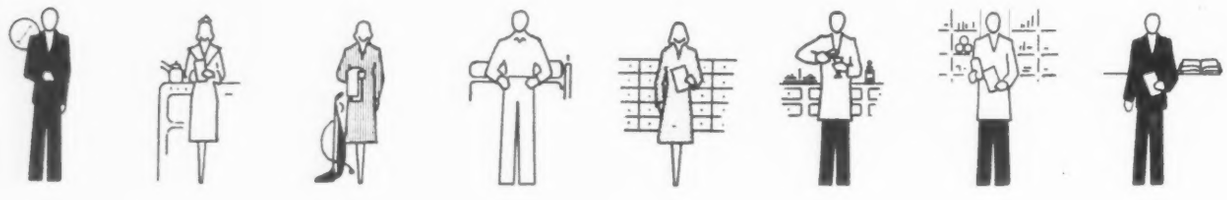
ADEQUATE SPACE must be provided for the comfort of the visiting staff. These facilities include a sitting room and private cloakroom, a bulletin board, lockers, telephones, paging outlet, clock, lavatories.

The location of the physicians' parking space will usually determine which entrance is used. In order to reach the staff room, they preferably will have to pass the information desk and the door of the medical record room. This arrangement permits efficient in-and-out registration and enables the record librarian to check on those who are lax about case records.

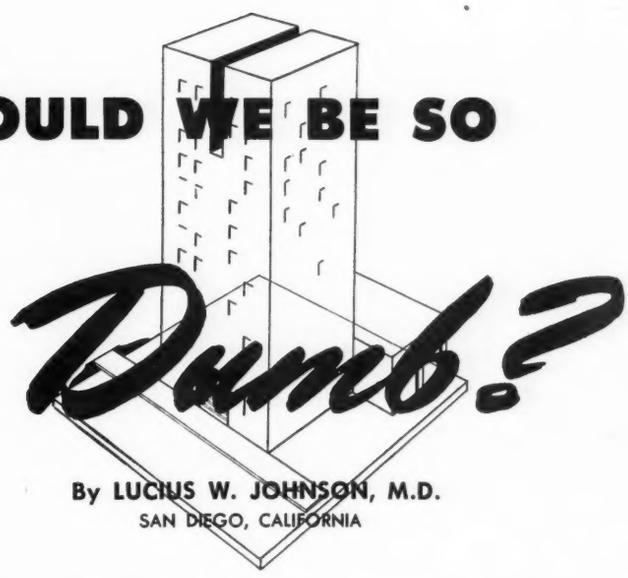
Space for staff conferences is needed and the staff lounge may be utilized for this purpose unless provision has been made for it in the board room, library or dining rooms. If so used, double x-ray view boxes should be built in.

PERSONNEL TOILETS

TOILETS FOR ADMINISTRATIVE PERSONNEL should be furnished in a convenient location on the main floor. In very small hospitals one toilet may suffice, or the public toilets may have to serve.



● HOW COULD WE BE SO Dumb?



By LUCIUS W. JOHNSON, M.D.
SAN DIEGO, CALIFORNIA

PEOPLE WHO, FULL OF HOPE and enthusiasm, have planned hospitals and then, full of self reproach, have had to live and work in the results of their planning often wonder how they could have made so many foolish, even tragic, blunders. They may find some small comfort in the fact that it can happen even to experts. For instance, there is the legendary tale of the great medical center, planned in every detail by specialists. Yet during the first year it was in operation more than $60,000 was spent to widen doorways so that a bed or a wheel chair could pass through.

Thirty-five years of hospital work, most of it spent in surgery, is not a complete and perfect training for hospital planning. This was one of my first discoveries after I was assigned to such duty several years ago. I didn't know a cricket from an ashlar, and I am still not quite sure which is a mullion and which a muntin. But there was plenty of opportunity to observe the errors of others, and I resolved that those mistakes should never be mine. No, my blunders should be new and startling ones that nobody else had thought of. As a useful guide to this policy I began to compile a list of common faults in hospitals, their planning and construction, which now has grown so large that it may be helpful to others.

Lack of vision in those who established a nice little neighborhood hospital in a new suburb has caused many a regretful sigh to succeeding generations. If only those founders could have been clairvoyant, could have seen that their small beginning would grow to a huge city hospital, no doubt they would have added another acre or two of land, at very little cost. Today, that hospital cannot expand to the capacity needed because the land values are too high for horizontal growth and zoning regulations prevent any addition to the height. The rule should be to obtain at least twice as much land as the most imaginative person on the board can conceive to be necessary.

One or more frugal minds among the founders can also cause headaches that will last for decades. An example of this was recently described by the director of a large and prosperous city hospital. "A parsimonious banker on my board," he told me, "figured that more than a thousand dollars could be saved by not excavating under a part of the hospital. Now I need that space desperately for storage. Access to it is so difficult that it would have to be dug out by hand, at great cost for labor. Or else I will have to put up a new building, inconveniently located, at a cost 50 times as great as if the basement had been provided at first."

Provide more space in every department than seems necessary. This legend should appear in large letters on every sheet of drawing paper used by hospital planners. Loud wails about lack of room are heard on every side. "Look at our little kitchen, big enough for 80 patients. But we have grown to 250 and there is no way to expand. It is so hot and crowded that we can't keep good workers and the turnover is terrific. No place to keep leftovers, which means shameful waste." Or else, "They cut down the size of our rooms to get one more in each wing. They are a little oversize for one bed but too small for two. And the door is so placed that you can't get a straight run for the wheeled stretcher to the bedside."

Another nice little, brand new hospital, of which the local architect was very proud, had nowhere any storage closets or rooms. A penny-wise member of the board had protested against such waste of valuable space. With a "five-and-ten" just around the corner, what did they need of all those cupboards? One housekeeper showed me with chagrin that there were no linen closets for any of the floors. There was an elaborate soiled linen chute, but it led to the furnace room below, and there was no provision there for handling the soiled linen.

The importance of records, the amount of space they occupy and the need of convenient arrangements for handling them are seldom appreciated by those who have not worked in hospitals. One 500 bed hospital which was recently visited had but one small room for records. It was hardly large enough for handling the charts of a single day's discharges. And a smaller hospital had no provision whatever made for records. They were cared for in the visitors' waiting room, where any casual passer-by might stop and enjoy reading the charts that were scattered about. It is a rare thing to see an institution which has sufficient space, good arrangement and facilities that will enable the librarian to keep the records as they should be kept, safe yet accessible.

The example of narrow doors, already mentioned, is by no means unique. Wider doors are also heavier. They require more massive framing and hardware, both of which run into money. So board members and architects are glad to save by using the standard sizes provided for homes. A director of nurses showed me a regrettable example of this in a hospital which was the work of a local architect, related to a member of the board. He resented the suggestion that a hospital consultant be employed, using the familiar argument that any architect could design a hospital and, anyway, he had a book that told all about it. Her complaint was, "Not a door in the place that will pass a wheel chair or a bed. A stretcher patient has to be carried from the hall to the bed, which takes two nurses—if we can get them. And they don't stay long with all this lifting."

It is surprising to note how many inexperienced planners, and some experienced ones too, forget that it adds greatly to the usefulness of hospital elevators if the doors are wide enough to admit a bed or a wheel chair. Here is an alteration that really runs into money if it has to be made after the building is completed.

Then there was the hospital which had its maternity department on the third floor with its nursery and delivery rooms on the second. The one elevator was too small to take a bed. The transfer required repeated lifting of the mother in various stages of her confinement, and it involved exposure of the infants while they were being taken from one floor to the other.

What hurt most was the extra time spent by the nurses in carrying the babies back and forth. It was the hospital rule to exclude all other persons from the elevator except the nurse and the operator while the infants were being transported. As the elevator was barely adequate to handle the traffic under normal conditions, there were infinite confusion and delay at feeding times, and much ill will was created by the poor elevator service.

Mention of the solarium brings to one's mind pleasant pictures of bright sunshine and pleasing colors that offer solace to mind and body. Yet it can become a white elephant, as one administrator explained to me. "This huge space was a nice sun room before our number of patients was trebled. Then it became an inconvenient annex to the adjacent ward. It is crowded with beds, without adequate toilet facilities, and it requires an inordinate number of nurses to care for the patients.

"In these days of early rising, a patient who is able to lounge in the solarium is fit to go home or to a convalescent hospital. I never want another solarium." Yet, in what used to be regarded as normal times, it was a delightful gathering place. If you have solariums in your new hospital, be sure to remember that they may some day be crowded; don't fail to provide toilet and nursing facilities for them.

Political considerations sometimes dictate decisions which may be full of possibilities for trouble in the future. Architects have been selected on a basis of relationship or affiliation, instead of ability and experience. Materials have been chosen because they were produced locally, or controlled by some influential person, not because they were best suited to the need.

A great deal of trouble of this sort has come to my notice that was caused by elevators. An important consideration in choosing an elevator is service. This question should be asked: When trouble arises, can an experienced man be obtained quickly to make repairs? If not, the whole hospital may be seriously incommoded for an indefinite time. The large manufacturers maintain complete service organizations in all parts of the country, so that users of their products will not be handicapped too much when some part of the mechanism of the elevator fails.

Speaking of elevators, don't forget to provide a special elevator for service, unless your hospital is very diminutive, or all on one floor. It keeps food, dressing carts, stretchers,

beds and other housekeeping details from interfering with patients and visitors. It also provides a useful, and sometimes a lifesaving, spare in case of breakdown of the main elevator. How many elevators should be installed? At least one more than you figure is absolutely necessary. I do not recall ever seeing a hospital with more elevators than were needed, and few have enough.

Who would believe that a group of planners could be so dumb as to design a multistory hospital and forget all about elevators? Yet it has happened more than once. A friend who has just left the government service told me of his experience in such a building. It was not until they started to move the equipment in that the omission was realized. In another case the deficiency was revealed when a bidder submitted two estimates, one to build the hospital in accordance with the approved plans and the other to build it with elevators.

In a hospital whose planners were headed by a surgeon, there were a beautiful surgery and an ornate morgue, while the laboratory was not much more than a cupboard. Dr. Warren P. Morrill of the American Hospital Association summed up this predicament in his characteristic way, "If the laboratory is so small they will need a big morgue." Such lopsided planning is not uncommon.

A medical director told me some of the troubles he had with a small town architect who planned his hospital and supervised its construction. "He figured that if the sterilizers and bedpan washers required only 15 pounds of steam pressure, then a 15 pound boiler would be sufficient. When his blunder was made evident we had to postpone the opening of the hospital. It was necessary to break through the heavy concrete wall to install the new boiler. The cost was so great that it took all the money we had allocated to building and equipping the maternity ward."

While showing me through his hospital an administrator told me this one. "A member of my board considers herself something of an interior decorator. A lot of money that was needed for kitchen and laboratory equipment was spent under her direction for frescoed walls, heavy velours curtains, brass handrails and travertine floors. The brass requires a full time worker to keep it bright and the polish stains the walls. The travertine floors have soft spots and holes which catch the high heels of the ladies. There have been several nasty falls which may end in damage suits. We tried to fill the holes with plaster or concrete, but the end result looks like the last stage of malignant smallpox."

"No nurse ever saw the plans of this building," fumed an old timer as she told me about the beautiful new wing that had just been opened. "If those know-it-all doctors would ask us about some of the practical points, we'd be glad to tell them. Lots of tile and bright work, but no conveniences. Here we have a big ward for women, but no examining room. When a doctor wants to listen to a heart or make a special examination we have to call another nurse, lift the patient onto a stretcher and wheel her down the corridor, across the lobby to the old wing, where there is a nice examining room."

A large hospital was nearly completed before any serious thought was given to disposal of its sewage. Then a large and costly treatment plant was built in the only space that could be obtained. which was 80 feet above the level of the hospital basement. Sump pumps were provided but frequently were either inadequate or out of order.

On such occasions the raw sewage overflowed the basement and entered a small stream which ran into a nearby lake, a popular summer resort. The contamination was sufficient to kill the fish in the lake and also to lend a certain fragrance to the countryside. Among the by-products of this poor planning were the bankrupting of several concessionaires at the resort and a tremendous amount of ill will for the hospital and all associated with it.

One of the trustees of a community hospital was a dealer in office equipment, and he presented to the institution an electrically operated adding machine. After displaying the gadget with great pride at a board meeting, he invited all hands to come to the office to see it work. But there was no electric outlet in the office and further search disclosed that there was not one single outlet in any room, office or ward of the hospital.

In another hospital operating rooms are located on each side of a narrow main corridor which carries a constant, heavy traffic. Groups of passers-by frequently have to stop, and they never fail to gape, while doors are opened and surgical patients in various stages of nausea and distress are wheeled by.

Another hospital was built without any expansion joints in the heating system. A doctor who was present when the heat was first turned on said, "The whole building was moved about 6 inches, and it

throbbed like a tractor engine. Fortunately, nothing exploded, but the building had to be evacuated for several weeks while the error was being corrected."

Record librarians are not the only forgotten persons, for a hospital was built without any office for the dietitian or the director of nurses. Nobody remembered them. Omission of utility rooms and spaces for nurses to do their charting has also occurred. Makeshift arrangements for these workers, who are the very mainspring of the hospital, make it difficult to retain those who are most competent and desirable. Most of them would rather go where working conditions are pleasant, even at a lower rate of pay.

The importance of toilets to human happiness is rarely appreciated until one is missing in the hour of need. Recently a visit was made to a hospital that had no toilet on the ground floor. Casual visitors were referred to one of the patient floors, which added much uncontrolled and undesirable traffic to those areas. The medical director commented to me, "When we plan our new building I am going to get some old man to select the sites for the toilets. He will understand the need for having them in strategic places."

While conversing with a group in the main corridor of a large, new hospital there came a sudden sound of rushing waters which drowned out the conversation. All of us turned instinctively to watch the door, 30 feet away, and see who emerged. It was a source of embarrassment to all of us as well as to the one who had flushed the toilet. A little forethought would have provided acoustical treatment of the toilet room and the corridor, an essential detail of hospital construction today. Toilet fixtures vary widely in the amount of noise they make, and this point should be studied before decision is made on the type to be installed in a hospital.

A cardiologist showed me an unfortunate example of the harm that can be done when good intentions are unwisely directed. There was need to install a blower somewhere to ventilate an adjacent space so, while the doctor was on vacation, the hospital authorities had a false ceiling built in his office and placed the blower machinery above it. "I might just as well have stayed away permanently," he wailed, "for I can't work here. The blower makes so much noise that I can't hear a heart beat. I have to shout when I want to take a history. There is too much vibration to use the electrocardiograph while the blower is running, and there is no way to turn it off when I want to do my stuff." Consequences of minor changes are often far reaching, sometimes unforeseeable, but they always require careful study.

Frederic W. Southworth has recently retired after a long and distinguished career as chief architect of the Bureau of Yards and Docks, Navy Department. During the decades that he was with that bureau he designed practically all of our present naval hospitals. Their beauty and efficiency are enduring testimonials to his ability. When the subject of this article was mentioned to him, he offered this list of errors which he has seen constantly recurring in hospital planning:

1. Concealed piping of poor quality that quickly corrodes and is inaccessible without tearing out walls and ceilings of offices or revenue-producing rooms.
2. Inadequate space in kitchens, record offices and engine rooms.
3. Builders who forget to install boilers or other machinery until the concrete walls are complete.
4. Penny saving by purchasing inferior plumbing fixtures, especially cheap plating.
5. White marble for toilet rooms, which quickly discolors with time and washing.
6. Inconvenient placing of switches.

This list of blunders may seem hypercritical, and they couldn't happen in your hospital, of course. But all of them *have* happened in new, modern structures, planned by experts. They have occurred over and over again, in spite of the wide publicity given them. Perhaps too much stress has been placed on mistakes made by architects, but the American Institute of Architects at its last meeting withheld support from the hospital architects' qualifying committee of the American Hospital Association, permitting the inference that any architect can plan a hospital and no special knowledge is required. This is as fallacious as it would be to contend that any person with an M.D. degree is competent to do surgery of the eye.

This point of view cropped up in the construction of a hospital with which I was to be connected. After long consultations with the heads of all departments, and many revisions, I took the layout to the man who was to build it. He pushed it aside contemptuously and said, "Doctor, don't tell me how to run my business. I am an engineer. I know how to build a hospital. I'll build your hospital as it should be built. Then, if you know your job, you can run it." The plan he proposed to use would have required 50 per cent more personnel than could be provided and there were many other obvious faults. It was only by prolonged and unhappy bickering that we finally got what we wanted.

Reciting the mistakes of others gives one a pleasant sense of superiority but it may inflate the ego to the danger point, so it seems advisable to reiterate that many of these errors were mine. Only the eagle eyes of others prevented them from being perpetuated in brick and concrete. To end on a positive note, the following admonitions, all well known but frequently forgotten, are set down for consideration.

1. Provide at least twice as much land as seems necessary.

2. Money spent to obtain the services of an experienced hospital planner will be wisely invested.

3. Group the diagnostic facilities together in a central, easily accessible location.

4. Keep traffic out of working spaces.

5. Don't forget to ask the nurses, dietitians, record librarian and heads of all special departments how they want things arranged in spaces in which they will have to work.

6. Don't try to build a hospital on a shoestring. Wait until there is money enough to provide adequate space and equipment.

7. Provide more space in every department than seems necessary.

8. Wide doors are needed for elevators and every space where a bed or wheel chair may need to go.

9. When preparing contracts for elevators and other fixed equipment, have a clause in the contract providing for service. Make sure that the other party is in a position to provide the service.

The Architect

HIS PURPOSE AND HIS METHODS

By **WILLIAM A. RILEY, A.I.A.**
ARCHITECT
CURTIN AND RILEY, BOSTON

HOSPITAL ARCHITECTURE IS RECOGNIZED today as one of the most complicated types of planning that any architect can undertake. The designing of a hospital is a highly specialized architectural and engineering task. The problems concerned with the proper housing of the ill are not of recent origin; they actually go back many centuries. In the early Greek and Roman days, the general belief was that the Gods could restore a sick body to health. Hence, patients were sheltered only in temples.

From the seventeenth century to the present time, progressive improvements in medical and surgical procedures have brought about many new problems, all of which demand that hospitals provide suitable facilities permitting scientific progress to go on unhampered.

The planning of a hospital today involves three fundamental factors: function, form and engineering. Hospital construction differs from that of most other buildings in that the functional plan is of primary instead of secondary consideration. One of the real problems of the hospital architect, for example, is to keep pace with the progressive changes and improvements in hospitals.

The effect of technical and engineering developments on planning must be studied constantly. Thus, the development of the operating room light means that hospitals need no longer be oriented for northerly exposure for operating rooms, since artificial light is more satisfactory than daylight. Similarly, improvements in technic in the obstetrical department, especially in the care of babies, have brought about radical

changes in the design of the nursery, and many other advancements in technic and engineering have changed hospital planning.

Our problem as architects is to keep pace with these improvements and protect our clients, the hospital board of trustees. The hospital architect should therefore become an associate member of the American Hospital Association, local and state hospital associations. He should attend local and national hospital conventions and subscribe to hospital publications. In this way he can keep in touch with the ever-changing hospital picture and acquaint himself with the people who keep our hospitals going.

Everybody who is interested in hospital architecture should visit the modern architect's office and see how he works. Modern professional practice has brought about changes in the architect's methods, just as it has in the hospital.

Today, the architect conducts many conferences with his client throughout the course of the building program. He renders valuable assistance in all questions entering into the selection of site and the complex dealings in real estate and appraisals. He prepares a survey of the owners' existing hospital facilities, analyzing these and outlining a step-by-step program for expansion and rehabilitation. Many times he is asked to prepare special drawings to be used in brochures for fund raising campaigns.

The architect also prepares all preliminary studies, sketches and schedules of materials and costs. He prepares working drawings and specifications and makes plans for heating, plumbing, electrical engineering and other mechanical requirements. He assists in the drafting of forms of proposals for bids and contracts with all contractors. He assists the owners in the receipt and tabulation of all bids received from contractors.

When work has started, the architect prepares all the large scale and full size detail drawings. He issues all certificates of payment and keeps track of all business accounts. He makes recommendations governing the general administration of the work—and he renders building supervision.

Because of the complexity of the modern hospital it may be useful here to suggest how important a good approach is for a hospital program. Since the majority of commissions are for expansion of existing hospitals, the following procedure has been found practical.

1. A COMPLETE SURVEY of hospital facilities needed for the area should be made.

The purposes of the survey are: to determine the need for increased facilities for all departments; to determine the allocation of space in existing buildings for the best functioning of the various departments; to present by tables and charts the past and present history of each department; to recommend the most practical location for any new buildings needed for immediate and future expansion; to estimate the potential income and operating costs for proposed and present beds; to determine the approximate costs for the various needs, arranged in a step-by-step program in order to allow the completion of each unit as funds become available.

2. THE OWNERS SHOULD SUBMIT to the architect a comprehensive survey of the building site, containing lot lines of streets, accurate contours of the land, adjoining property lines, rights and restrictions, easements. The survey should also contain the location of existing buildings, full information in respect to utilities, such as sewer, gas, water and telephone.

Information in respect to soil conditions is extremely important and necessary. Legally this is the owners' obligation and responsibility. All hospitals should keep a complete set of drawings of all existing buildings. The hospital architect cannot proceed without accurate information about the present plant. If the trustees knew the necessary expense involved in preparing plans of existing buildings, they would be careful to keep these drawings filed for future use.

3. A SPECIAL SET of "as is" drawings at small scale should be prepared which will contain all major items, such as the location of the various departments and general circulation, *i.e.* stairs and elevators. The "as is" drawings should indicate the general elevations, with floor heights and sections through all existing buildings, showing the relationship to adjoining grades.

4. WITH THE "AS IS" PLANS reduced to small scale, usually by a photographic process, and the hospital survey, the hospital architect is now ready to make studies or schematic drawings showing the possibilities of expansion, allocation of new and present departments for present and future needs.

The first conference with the building committee should cover only the major items, such as the location of departments, sizes and number of nursing units and possibilities of expansion, supported by simple, single line drawings with rough estimates of costs for each step of the program. It is well to keep the presentation as simple as possible. Departments and services may be presented in different colors. One set of drawings may be mounted on heavy cardboard and exhibited in numerical order in the architect's conference room.

At the first conference, the architect should explain the purpose of the meeting, the need for cooperation, the method of procedure and his recommendations based on his findings and study. Following this, the architect may unveil the mounted drawings.

With his experience and professional training, the architect can digest all the ideas presented by various

members of the building committee. He wants their opinions and views. He also wants them to be frank and honest, especially in the matter of the available funds. The architect will then be in a good position to point out the possibilities of their ideas.

Of course, the architect should make certain that the procedure and information needed if the hospital is planning to seek grants under the Hospital Survey and Construction Act are fully understood.

The next step is the development of double line drawings. These schematic drawings will show the arrangement of all the rooms and the various departments; sketches of circulation and travel distances; areas and breakdown of facilities. Meetings are requested to review this work. It is wise to present copies of these drawings for the committee's perusal and study for subsequent meetings.

It is assumed that the various department heads will be permitted to consult with the architect at this stage. Again, the architect will respect their views and opinions, and he, in turn, will find out all the things he has left out and the probable increase in costs to his budget. Many meetings and conferences are also necessary to discuss building codes, local and state laws, availability of materials, a time schedule of construction activity, detailed costs, exterior and interior details and types of construction.

All the foregoing data must be carefully prepared before the board of trustees' approval to proceed with the working drawings is requested. With the commencement of the working drawings, the architect should continue to submit the detailed drawings to the building committee for review.

At this time also the problems concerned with the hospital equipment and furnishings should be considered. The various rooms are designed around the equipment; color plays an important part in hospitals today, and the proper selection of furnishings is something the architect is qualified to discuss.

It may be interesting here to describe briefly the architect's office and the methods employed to expedite work. As a rule, the architect's office is not large. Since the work is to a large extent creative, the close personal touch is absolutely essential.

Beside the key men of the organization, with secretaries and office staff, the architectural office usually has an office manager, who collaborates with the designers, draftsmen and engineers. The office contains a mechanical engineering department, which includes the electrical engineer, the sanitary engineer, the heating engineer and the structural engineers. Each mechanical department has draftsmen trained in their respective fields.

The members of the firm usually handle all the preliminary phases of the work, dealing directly with the clients. Of course, during the early stages of planning consultations will be necessary within the architect's office. When the program has reached the working drawing stage, the project is turned over to the various engineering and drafting departments. When it is ready for bids the drawings and details are handled by a contract department of the organization. When actual construction has commenced, the detail department, in conjunction with the inspection department, will take over.

In all these processes, the hospital architect himself must keep in close touch with developments and inform his clients of all activities. Weekly progress reports are a useful and helpful device. Many architects keep a job diary of all activities, a history record of the project, a copy of which is turned over to the board of trustees at the conclusion of the work.

In a large building program, it is necessary to allow sufficient time to prepare the final contract drawings and details. Many times it takes as long to prepare the material as it does to erect the building (in normal construction years). This time is absolutely necessary; clients would never request an architect to prepare plans in several weeks if they knew the work involved and the possibilities of omissions resulting from unnecessary haste.

Architects should never start any program without signed articles of agreement. These contracts will definitely state the work involved, the steps and the compensation. Faithful adherence to the rules and regulations contained in the signed contract should be mandatory. The architect must always keep in mind the funds available for the program and keep within them. The hospital's board of trustees has a definite responsibility to its community in providing the most adequate and best services needed to maintain health and happiness.

The hospital architect of the future will be the leader of an organization of competent specialists, offering expert assistance in every phase of building, utilitarian and economic as well as esthetic.

HELPING Greece TAKE THE ROAD TO HEALTH

By GEORGE XANTHAKY
EXECUTIVE VICE PRESIDENT
GREEK WAR RELIEF ASSOCIATION

ONE OF THE MOST DISASTROUS EFFECTS OF THE war in Europe is the present poor state of health of the Greek people. Greece is normally a poor country; its raw materials are negligible; the soil is poor, and food production has never been sufficient to satisfy the minimum requirements of the people. As a result, the diet of the Greek people in general has never been brought up to what is considered standard.

During three and one half years of Axis occupation the Greek people were subjected to a deliberate policy of starvation equaled only by that inflicted upon the Polish people. The toll of famine and death rate was appallingly high. The health of most of those who survived was permanently affected, especially the health of children.

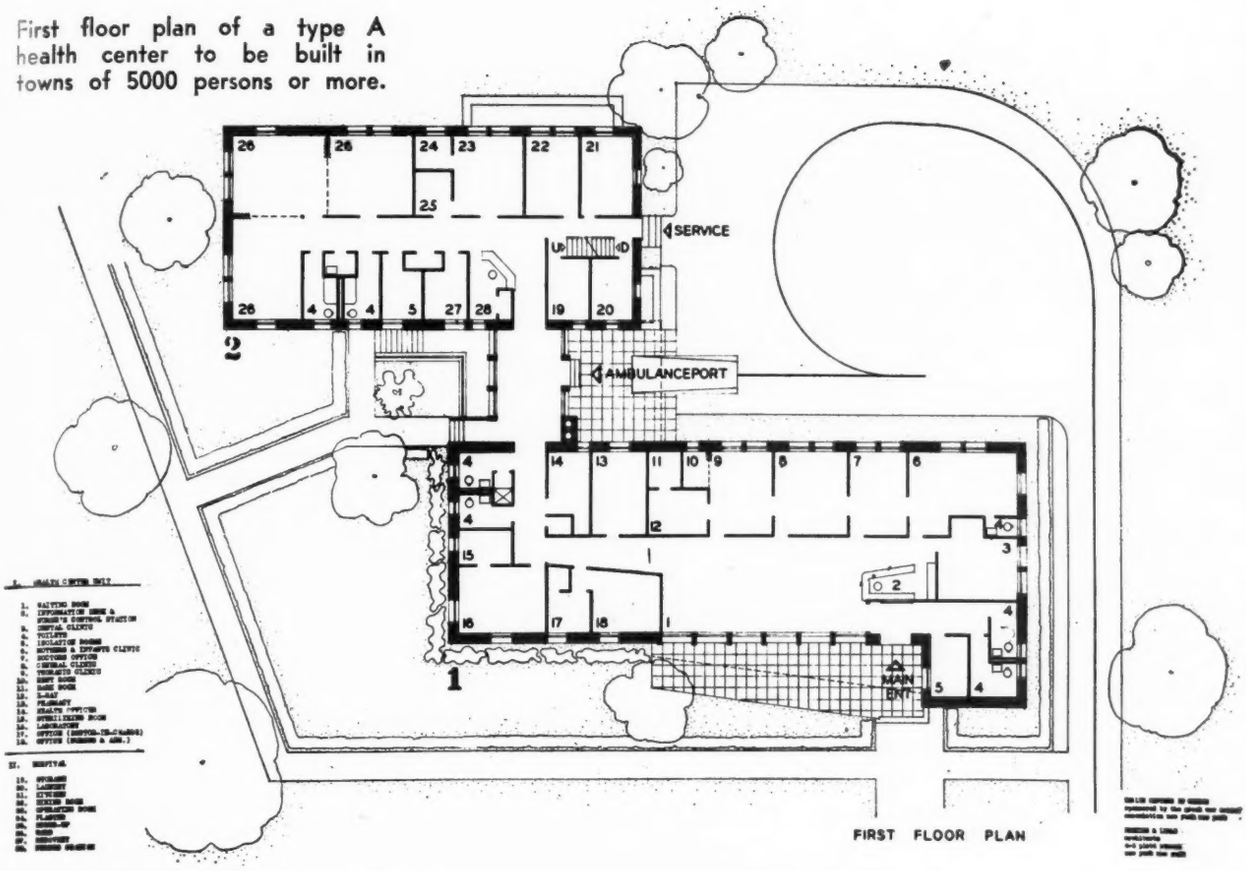
In 1945, 75 per cent of the Greek children were undernourished. Youngsters now reaching the age of 14 are 3 inches under normal height and 15 pounds underweight. One per cent of the entire population, or about 75,000 persons, will die of tuberculosis alone during the next three years unless drastic steps are taken.

Improving the health of the nation is the most serious problem facing the Greek people today. The major part of the work of U.N.R.R.A. in Greece is directed toward this end. The Greek War Relief Association, the only other relief agency doing work in Greece, is concentrating all its efforts on providing immediate medical assistance throughout the country and on laying the foundation of a long range program which will provide adequate medical care.

The first part of the program is carried out by means of mobile clinics and temporary community

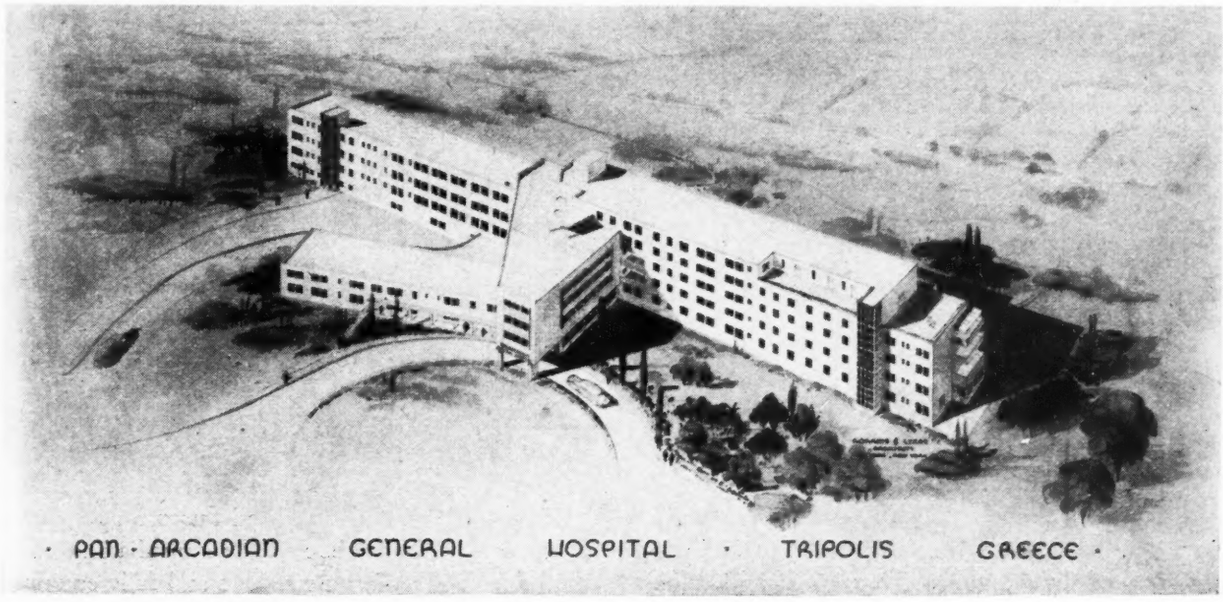
The maternity unit on the fourth floor of the Pan-Arcadian General Hospital, Tripolis, Greece.

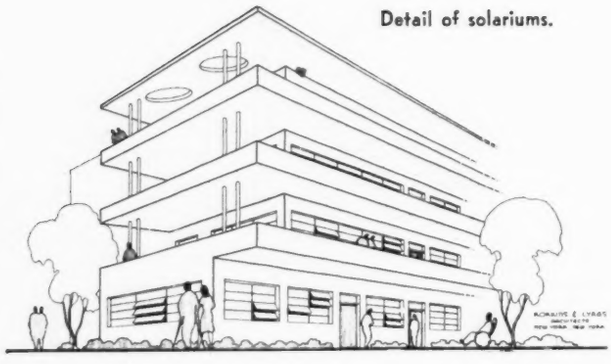
First floor plan of a type A health center to be built in towns of 5000 persons or more.



outpatient clinics spread over the entire country. At the present time there are 40 mobile clinics and 494 community clinics operating all over Greece. Each mobile clinic is staffed with one doctor, one visiting nurse, one assistant nurse and a chauffeur. Each community clinic is staffed with one doctor and one nurse. The total number of people served by these clinics is 1,800,000 out of a total population of 7,500,000.

The second part of the program consists of building permanent medical establishments, such as health centers and hospitals. This is an enormous undertaking because, with the exception of the capital city of Athens, Greece, even in peace times, suffered from a





Detail of solariums.

serious lack of such facilities. Before the war the total number of hospital beds was 20,680, or one bed per 400 population. Less than 30 per cent of these beds were located outside of the three principal cities, Athens, Piraeus and Salonica.

Not only did the war and the Axis occupation multiply the need of medical care, but most existing hospitals were deliberately and systematically stripped of their equipment and supplies by the invading legions.

In spite of the size and scope of this program, however, the Greek War Relief Association has fully committed itself to this work. At the present time this program provides for the erection of health centers where no medical facilities are now available. Several types of health centers will be built depending upon the requirements of the various localities.

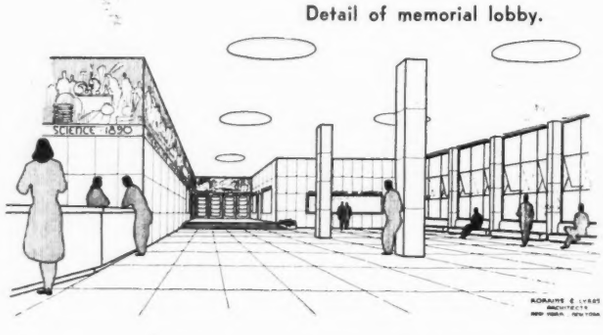
As the first part of the program, it was decided to use type A centers, a plan of which is reproduced on page 69, for towns of 5000 or more. The erection of 24 of these centers is now about to begin in various locations of the mainland and the islands. This plan provides complete facilities for preventive medicine and clinics for outpatient care, a section for emergency surgery and hospitalization, headquarters for visiting nurses and health inspector, nurses' and doctors' residence quarters and public baths.

A smaller building, type B, is planned for communities of 5000 or less. The facilities provided in this plan for preventive medicine and outpatient care are identical with those in type A, but no emergency wing in included. All emergency cases will be treated as first aid cases in one of the general clinics and then taken to the nearest hospital or emergency clinic by ambulance for further treatment.

A total of 150 of these buildings is at present contemplated as sufficient to provide basic medical care for the major part of the country. (The problem of the small islands with small and scattered population is still to be solved.) At the present time no such buildings exist in any part of the country. The governing body of the Greek War Relief Association has accepted the recommendations of leading authorities in the field of public health and has decided to pursue this plan to the full extent of its financial resources.

Side by side with the health centers, the present plans of the Greek War Relief Association provide for new hospitals or reconditioning of existing ones wherever this is deemed advisable. Large organizations of Americans of Greek origin are often moved either by local interests or by the desire to help the country of their origin in some distinctive manner. In some cases such efforts coincided with the present public health policy of the Greek War Relief Association. As a result the association has joined hands with such groups and has proceeded to undertake the planning and construction or the reconditioning of hospitals.

The first hospital to be so planned is the Pan-Arcadian General Hospital at Tripolis, Greece. In partnership with the Pan-Arcadian Society of Amer-



Detail of memorial lobby.

ica, whose members hail from Arcadia, the Greek War Relief Association will build a 256 bed hospital. Plans for this hospital have been prepared by Kokkins & Lyras, New York architects, with Isadore Rosenfield as hospital consultant.

Dr. Katsoyannis, director, and Mr. Biris, chief architect, of the Ministry of Hygiene of Greece, have also served as special consultants at the request of the Greek War Relief Association. On the basis of their advice, the plans were adapted to conditions prevailing in Greece in regard to administration, essential services, habits and traditions affecting personnel and general living conditions.

This hospital has some special characteristics. For instance: The wards are kept to a maximum of six beds. Comparatively few private rooms are provided inasmuch as the people in the area served by the hospital are generally poor. No nurseries are provided in the maternity wing (a floor plan for which is shown on page 68); bassinets will be located next to the beds. Complete and up to date diagnostic and treatment facilities in x-ray and fluoroscopy are provided with a capacity beyond the immediate needs of the hospital. There is a complete and fully equipped

outpatient department. Modern kitchen and laundry equipment is operated by steam and electricity. Other features include fluorescent lighting, air conditioning of operating suites and darkrooms.

The school of nursing will accommodate 75 students, 25 of whom will be graduated annually. Graduates from this school are meant to serve not only in this hospital but also in the rest of the health services provided by the Greek War Relief Association. The nucleus of this corps of nurses will be formed by 50 nurses now being trained in England for a four year period under the auspices of this association.

The hospital is completely fireproof and has its own power plant and sewage disposal system.

In addition to the service to the city of Tripolis and its immediate vicinity, this hospital will be linked with all other medical facilities of Peloponnesus for all cases requiring specialized treatment and special equipment for diagnosis. As part of this program the Greek War Relief Association is now about to begin construction on three type A health centers in this area and is considering plans for the modernization of an existing 60 bed general hospital and its future expansion to 120 beds.

This area has a population of about 1,065,000. The Greek War Relief Association is now operating 92 community clinics in Peloponnesus and several mobile clinics which serve 400,000 persons. At present there are 400 beds available in this area, or 4 beds per 10,000 people. However, most of these beds are in tuberculosis sanatoriums and almost all of them are in structures which, unfortunately, one can hardly call hospitals.

In planning this hospital, the architects have tried to take full advantage of the temperate and fairly dry climate of this locality. Natural light and ventilation are provided to the fullest extent. Orientation and commanding views are ideally combined. Configuration of the site is handled to great advantage as to cost of construction, efficiency of operation and esthetic grouping of building masses.

The Greek War Relief Association and its architects are working on this program in close cooperation with officials of the Greek government. Plans already worked out by the Ministry of Hygiene are being given careful consideration and every effort is exerted to fit as much as possible into the official scheme all new work originating in America. To what extent this contribution of America to the health system of Greece will ultimately be carried depends upon the successful completion of the part now under contract and upon the generosity of American citizens, especially those of Greek origin.

Psychiatry

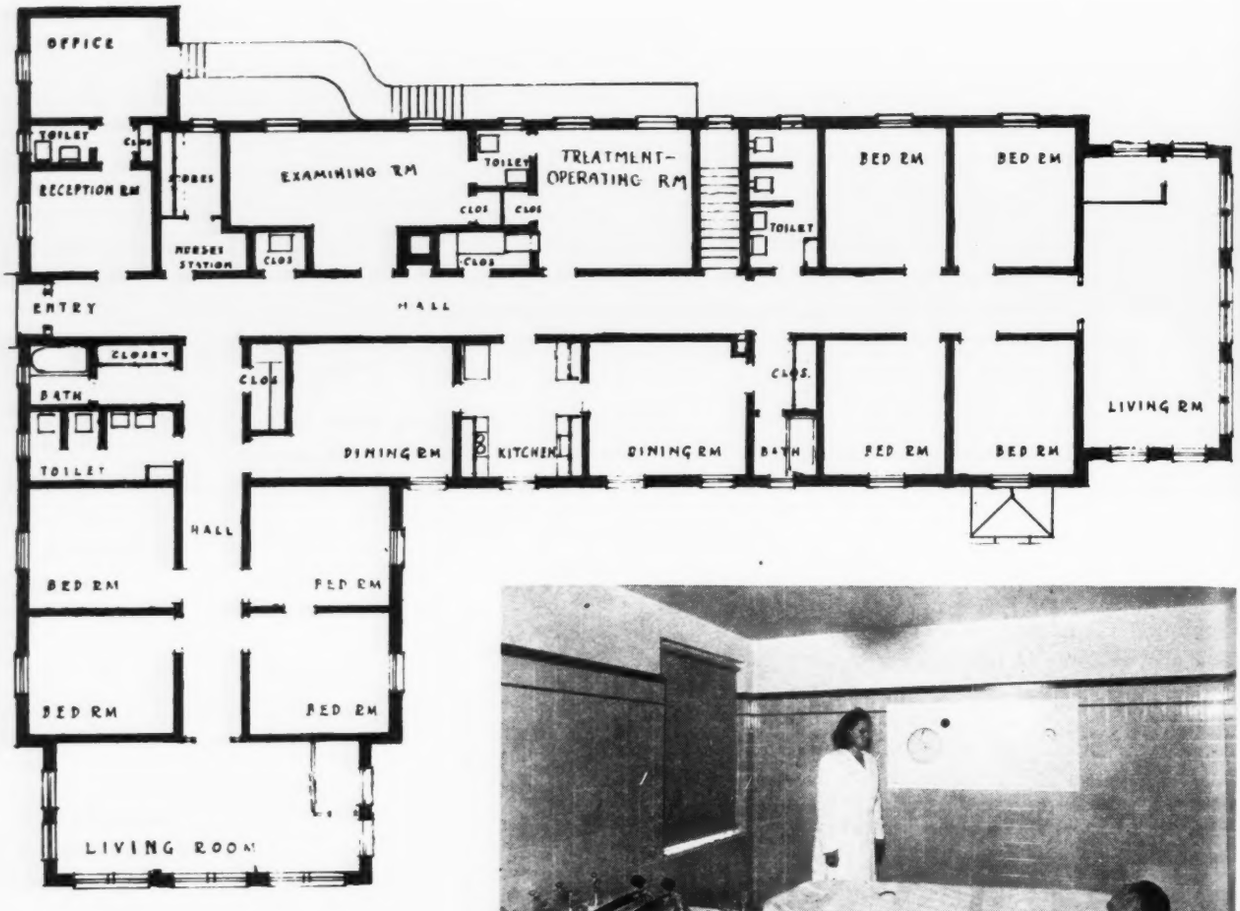
MODERN QUARTERS FOR THE MENTALLY ILL

By ALBERT L. CRANE, M.D.
DIRECTOR
CLEARVIEW SANITARIUM
EVANSVILLE, INDIANA

IN JUNE 1945, CLEARVIEW, A SANITARIUM at Evansville, Ind., formally dedicated a new diagnostic and treatment building to meet the demand for private psychiatric care, which had overcrowded the original hospital, a converted 16 room residence. While this building provides sleeping quarters for 16 additional patients, the motivating thought governing its construction was to provide proper modern diagnostic equipment and treatment facilities.

A happily unavoidable corollary is, of course, the fact that acutely ill and convalescent patients can henceforth be cared for in separate buildings. The new building will be devoted exclusively to the care of acutely ill patients.

As illustrated in the photograph on page 73 the building is L-shaped. The long wing is 97 by 30 feet and the short wing, 32 by 30 feet. The building is constructed on a gradually sloping hill with the long arm of the L projecting downward. Thus throughout



Above: Plan of the first floor of Clearview, which houses administrative offices, examining room, hydrotherapy, laboratory, drug closet, laundry and furnace room. Right: The hydrotherapy room with continuous flow tub.

two thirds of its length the building is two stories high.

The plan of the main floor is shown in the accompanying illustration. In addition, the ground floor provides a secretary's office and waiting room, offices for the medical director and associate physician, examining room, hydrotherapy, clinical laboratory, laundry, drug closet and furnace and coal rooms.

The building throughout is of masonry construction with brick veneer finish and floors of steel reinforced concrete. The roof is constructed of wood and covered with asbestos tile shingles. The ground floor is finished with asphalt tile and the main floor with linoleum. The hydrotherapy room has light green ceramic tile flooring and wainscot reaching within 2 feet of the ceiling.

Patients' living quarters are equipped with 32 psychiatric screens.

The heating plant is a modulated controlled blower system with steam coil units and compressor for cooling during the summer. All drinking water is electrically cooled.

The lighting is fluorescent set flush into the ceiling and all switches in the patients' living quarters are controlled by a special key.

A special functional feature is an intercommunication system with seven stations located at key points throughout the building.

The cost of the building, not including land, furniture, equipment or architect's fees, was $53,470. Including these items, the total cost was $74,500. The total volume of the building is slightly over 88,000 cubic feet.

The architect was John F. Hagel of Evansville, Ind. Although Mr. Hagel's professional experience had included the planning of many different types of

New diagnostic and treatment building at Clearview is built on a hill with long wing projecting down.

buildings, this was his first effort in planning a psychiatric hospital. The success which he achieved must be attributed, in part at least, to the helpful cooperation of Dr. Samuel W. Hamilton, U. S. Public Health Service, Washington, D. C.

The interior decoration of the building was designed by Richard H. Brennan, also of Evansville. The principal feature of the interior treatment was the designing of functional built-in furniture for the entire building, which gives the effect of apparent room size greater than the actual dimensions and at the same time greatly increases the efficiency of the building for the purposes for which it is intended.

Considerable attention was also given to color. All working rooms are finished in eye-rest green. All corridors, being interior, are painted in sun yellow with sufficient red to offset the effect of fluorescent lighting. Half of the patients' bedrooms are painted in a stimulating peach tone and the other half in a soothing yellowish green. In actual operation it is planned, insofar as possible, to place depressed patients in the former rooms and excited patients in the latter.

The director's office is finished in Swedish modern; the business office, in white bleached birch against periwinkle blue walls, and the associate physician's office is so designed as to function efficiently both as an examining room in the day time and as comfortable living quarters at night.

Equipment includes a stereoscopic x-ray machine, three channel electroencephalograph, basal metabolism apparatus, electrocardiograph, steam pressure autoclave, shock machines, continuous flow tub, Scotch douche and needle spray shower, pack table and the usual laboratory equipment.

The overall plan for the development of Clearview during the next decade includes the construction of "middle house," which will feature a public hall for group patient activities, an occupational therapy building and another structure designed for the comfortable accommodation of the senile group.

MORE ON HOSPITAL PLANNING

In coming issues, The MODERN HOSPITAL will present succeeding chapters, dealing with other hospital departments, of the text on hospital planning prepared by the Division of Hospital Facilities of the U. S. Public Health Service.

REGULATIONS Under Public Law 725

IF EVERY hospital administrator, architect and consultant concerned with building or planning will use the outlined minimum standards and, in addition, will work with the experts representing the Hospital Facilties Division in the U. S. Public Health Service area offices, the cause of really good hospital design and construction will be advanced tremendously. Public Law 725, its objectives and its attendant regulations and standards present a real challenge to everyone in our field; wholehearted cooperation of federal, state and local officials, national, regional, state and local hospital associations and individual hospital executives will result in the start of a coordinated hospital system for the United States.—EVERETT W. JONES.

THE *Federal Register* for Feb. 12, 1947, contains the complete regulations and hospital construction standards as developed by the U. S. Public Health Service and approved by the Federal Hospital Council. Knowledge and understanding of these facts are important for all hospital administrators and architects, who may order copies from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C.

A digest of some of the fundamental standards is presented here:

1. Hospital service areas are defined and designated as *base, intermediate* and *rural*.

Base Area: Of at least 100,000 population, it shall contain (1) at least one general hospital of 200 or more beds, approved by the American College of Surgeons and also by the A.M.A. for internships and at least two or more residencies, or (2) a teaching hospital of an approved medical school.

Intermediate Area: Of at least 25,000 population, it shall contain at least one general hospital of 100 or more beds.

Rural Area: Any area so designated by the state agency, no part of which is included in a base or intermediate area.

Regulations do not prohibit any type of hospital area from including parts of more than one state, provided there is an agreement among the states involved. Examples are Memphis, Tenn., and Sioux City, Iowa.

2. "Hospitals" are defined as public health centers and general, tuberculosis, mental, chronic disease and related facilities, such as laboratories, outpatient department, nurses' homes and schools and all service facilities operated in connection with hospitals. Institutions primarily giving domiciliary care are not included.

3. The number of beds per thousand of population for various types of hospitals are given as follows: *rural areas,* general hospital, 2.5 beds per thousand; *intermediate areas,* 4 beds per thousand; *base areas,* 4.5 beds per thousand.

Inasmuch as the overall maximum state allowance is 4.5 beds per thousand, the difference between 2.5 and 4.5 in rural areas is added to intermediate and base areas, and the difference between 4.0 and 4.5 in intermediate areas is added to base areas. In other words, an intermediate area can have a few more than 4.0 beds per thousand and a base area, considerably more than 4.5 beds per thousand.

The total number of beds needed for all areas in the state can be distributed at the discretion of the state agency without regard to the foregoing standards.

4. Maximum state allowance for tuberculosis hospitals is 2.5 times the average annual tuberculosis deaths; for mental hospitals, 5 beds per thousand population, and for chronic disease hospitals, 2 beds per thousand population. When it is practical, new tuberculosis, mental and chronic disease beds shall be built in centers of population and in proximity to general hospitals.

5. The regulations give maximum state allowance for public health centers as 1 per 20,000 or 30,000 population, depending upon the density of population.

6. In determining priority of projects, the state agency shall develop its construction program in relation to proportionate need for each of the five categories of facilities: general, mental, tuberculosis, chronic disease and health centers. New hospitals and additions to existing hospitals shall be given priority over replacements. Exceptions to this are made in case of hospitals that constitute a public hazard so that replacement is essential. No. 1 priority goes to general hospitals in areas in which need is greatest.

Chronic disease, mental and tuberculosis projects to be operated in connection with general hospitals shall have a higher priority than have those to be operated as separate hospitals. No application for a psychopathic hospital (acute intensive treatment) of more than 500 beds or of a mental hospital (long term custodial care) of more than 3000 beds shall be approved. As a general rule, no application for a tuberculosis hospital of fewer than 100 beds will be approved.

7. General standards of construction and equipment have been drawn up by the architectural section and consulting subcommittee that will do much to improve hospitals. Together with some other technical advisers, this group has produced a "bible" of construction standards that represents a wide cross section of experience.

Because these are minimum requirements it is desirable only that they form a basis for development of higher standards. In the interest of promoting the development of higher standards it is the intention of the U. S. Public Health Service to make suggestions and disseminate the latest information as to current practices in planning and design of health facilities. This information will be distributed from time to time to state agencies and other interested persons.

Hospital Income

Under Pending Legislation

MICHAEL M. DAVIS
Committee on Research
in Medical Economics
New York City

LATELY I have been studying no fewer than eight "programs." They have taken me up hill and down dale and around Robin Hood's barn, asking four questions that must be answered whenever hospitals are receiving payments from insurance funds or from governments:

1. How much will the hospitals be paid?
2. How will the rate and method of payment be determined?
3. What proportion of total hospital income will these payments constitute?
4. How much outside supervision or interference with hospital autonomy will there be?

Seek Full Costs of Care

First in primacy in our field is the program of the American Hospital Association itself, asking that our governments—local, state and national—pay voluntary hospitals the full costs of care of patients for whom these public authorities have responsibility. When a joint committee of the American Hospital Association and the American Public Welfare Association was meeting, some years ago, one member remarked plaintively: "Why have welfare departments and hospitals had such poor relations?" Quipped another member in reply: "Why, the hospitals have *been* the poor relations!" Certainly, at that period the voluntary hospital was too often paid merely token sums for caring for clients of welfare departments.

A decade ago, this joint committee worked out the policy of per diem payments on a cost basis and of group instead of individual bargaining with hospitals. Since then, public payments to voluntary hospitals have increased in total sum and have moved toward fairer levels in rates.

Meanwhile two wartime programs have come in: E.M.I.C. for servicemen's wives and babies, and the Veterans Administration's plan for looking after veterans in civilian hospitals. Here the federal agencies accepted the per diem cost basis from the start. The actual management of these programs has been such, on the whole, as to give hospitals more confidence that public payments will be fair. There are still some state and local welfare departments that yield grudgingly their long time habits, but the program of the American Public Welfare Association, favoring federal aid to the states for adequate care of "assistance" and "general relief" cases, advocates payments to hospitals on a cost basis, fairly negotiated.

The official "health program" of the American Medical Association, adopted in 1945, covers the same point. It declares: "This program for national health should include the administration of medical care, including hospitalization, to all those needing it but unable to pay, such medical care to be provided preferably by a physician of the patient's choice with funds provided by local agencies with the assistance of federal funds when necessary."

In a great many counties in different parts of the country, notably in Maryland and Kansas, the medical societies have contracts with public welfare or public health departments for paying doctors for the care of welfare clients.

The Blue Cross endorses the same principle. Its program as adopted by the Blue Cross Commission and approved by most, though not all, of the 85 Blue Cross plans favors "community and governmental encouragement and assistance to permit voluntary plans to enroll the low income groups." In practice, this would mean subsidy by payments from employers or from public taxation or from both.

Compare the programs of these hospital, medical, welfare and insurance organizations with those of 10 or even five years ago. There is substantial change in regard to public payments for service. Tolerance has given way to acceptance. In considerable degree acceptance has been replaced by advocacy.

These changes are reflected in proposed national health legislation. Last year the difference between two bills was sharply brought out. The Wagner-Murray-Dingell Bill based the national health program on the principle of insurance. The Taft-Smith-Ball Bill proceeded on the principle of public charity. This year this contrast will be even more emphasized. To hospitals, the similarities of these bills are as important as are the differences.

Tax Support the Only Answer

Under either a national health insurance program or a tax supported program, hospital service to indigent persons would continue to be paid for by local and state taxes, with federal aid. Except for the limited sums obtainable from private charity, there is no other way in which the bulk of it can be paid for. Each of the four national health insurance bills introduced into Congress since 1942 has included federal tax grants for medical care of such persons.

Under the national health insurance program, state and local welfare departments could pay, in behalf of their "clients," an agreed amount into the health insurance

fund, which, in turn, would pay the hospitals when services had been rendered. Under this insurance program, welfare departments would also have the alternative of continuing, as they do now, to provide directly for care in governmental or voluntary hospitals and to pay for it accordingly.

In either case, in order to be satisfactory to the hospitals, the administration of the funds would have to be sufficiently localized (as a national health insurance bill must provide) so that decisions and adjustments would be made through face-to-face dealings, not by means of black marks on paper shuttling to and from Washington.

Senator Taft's bill would face the hospitals with similar problems of working out rates and methods of payments with public authorities, state or local. From the point of view of the hospitals, there would be little difference between the two bills so far as concerns the payment for old age assistance cases and for *legally indigent* persons, *i.e.* those who are receiving part or all of their subsistence (and hospital service when required) from public funds. The majority of such indigent persons are and would remain under the jurisdiction of public welfare departments, and the bulk of public payments in their behalf would continue (under either bill) to come from local and state taxes.

Here Is Where They Differ

Move beyond the circle of the legally indigent, however, and the two bills differ widely. Under national health insurance, nearly all self employed and employed persons would pay a small percentage of their earnings into the health insurance fund. They and their dependents, *i.e.* the great majority of the population, would thus be entitled to care, when they needed it, as a matter of right, not as charity. Under Senator Taft's bill, certain federal grants would be available to any state which set up "a statewide program designed and calculated to provide within five years . . . services . . . for all those families and individuals in the state having insufficient income to pay the whole cost of such services."

Thus the only "families and individuals" eligible for benefits under Senator Taft's bill would be the legally indigent and the much larger group of the "medically needy."

Who are the "medically needy"? People who are not on relief or public assistance, but who when sickness comes cannot meet the costs of hospital and physicians' care. As all readers of The Modern Hospital appreciate, a large proportion of the population is "medically needy" so far as hospital care is concerned. In 1945, a year of high employment and exceptional earnings, 69 per cent of family incomes in the U. S. were under $3000, nearly half were under $2000 and 20 per cent were under $1000.

Ability to pay hospital costs does not depend merely upon income; it depends also upon the size of the family and the savings and other resources at the time the illness occurs. Many people could sometimes pay all or a large part of a hospital bill and at other times could pay little or nothing. "Medically needy" is not a status but an occasion. Ability to pay also depends greatly upon the size of the hospital bill—and this may run from a few dollars to many hundreds of dollars.

Most of the "medically needy" would be covered by national health insurance, whereas under Senator Taft's bill people would have to be investigated before they could be covered. The states or the local governments would set the standards of the means test.

Senator Taft proposes to aid voluntary nonprofit insurance plans by authorizing public payments to such plans of all or part of their premiums in behalf of needy persons. But "medically needy" persons cannot be enrolled as an insurable group. When such persons (assuming they had been classified as "needy") are members of a sizable group of employes, they could be enrolled at low rates, and the difference could be made up by subsidies, *provided* the employer would be willing to accept the scheme and do the extra bookkeeping and *provided* the employe himself and his union would say "yes" under these conditions.

In many rural sections where Blue Cross has little membership, the larger part of the population would be classifiable as "needy" for the purposes of this program and low rates and high subsidies would be necessary. Even then, voluntary enrollment of most of the families is doubtful. Altogether, this formula for "aiding voluntary nonprofit insurance plans" would be a headache rather than a gold mine for the Blue Cross.

There are other formulas whereby Blue Cross could use public subsidies. One rough and ready one is like this: Every wage worker or farmer earning less than a specified amount, determined locally, would be insurable at half rates, the difference to be paid the Blue Cross from the federal-state tax grants. How much would this rate reduction increase membership, considering the additional administrative and moral complications? Blue Cross executives should look into this and similar questions realistically.

Blue Cross Is Intermediary

Another method, specifically permissible under Senator Taft's bill, would enable Blue Cross plans to act as intermediary between the voluntary hospitals and the public authorities. The Blue Cross would be paid on *a case basis* (cost of care plus an allowance for administrative expenses) for any person who was certified as needy. Then the Blue Cross would pay the hospital.

Thus, the Blue Cross would serve as an agent of the hospitals in working out rates and other problems with the welfare department or other authorized body. How much benefit would this plan be to the hospitals, the government, the Blue Cross, as compared with direct dealing between the hospitals and the government? The answer might vary with the state and community.

Now we come to the third question stated at the opening of this article. Under either national health insurance or the Taft-Smith-Ball Bill, how much of the income of voluntary hospitals would come from organized sources as distinguished from individual patients?

Under national health insurance, the Blue Cross plans could continue, acting as agents of the hospitals both in making administrative and financial arrangements with the local and state insurance authorities and also in enrolling people for supplementary benefits—*e.g.* private and semiprivate rooms—beyond what the public system offered. Under national health insurance, probably from 80 to 90 per cent of the income of most of the hospitals would come from thre

organized sources: the national health insurance fund, Blue Cross plans and tax funds (paying for indigent patients). Payments and services would be the same for the needy as for other persons.

How would it be under Senator Taft's bill? The answer would depend chiefly upon the size of the appropriations made by Congress. In the 1947 bill, $200,000,000 from federal funds is authorized. The states would have to put up at least their present expenditure "for similar purposes" of medical and hospital care. Hence, the amount of new money would be much less, probably not more than $300,000,000.

This sum would have to cover physicians' and other services, besides those of general hospitals. General hospitalization would not get less than about $150,000,000 a year, of which about half would probably go to county, city and state hospitals and not more than $75,000,000 to voluntary hospitals. If this amount of public money were distributed to those states and localities in which it would do the most good, it might assure adequate hospital care for the legally indigent throughout the country.

Such a program is not big enough for hospitals or Blue Cross plans to be either enthusiastic or frightened about. If appropriations were later increased, how much, how soon, would they give our country a largely tax supported hospital system? Who can answer such an "iffy" question?

The trend of popular sentiment and the expressed policies of professional bodies ensure the growth of insurance and an expansion of tax support. Hospitals may therefore expect a larger and larger proportion of their income from insurance funds, governmental or private, and from tax funds, local, state and national. Thus, hospitals must certainly look forward to working out their financial destinies with a few organized public and semipublic agencies with which rates and methods of payment must be negotiated and mutually amicable relations must be maintained.

Under these conditions "how much outside supervision or interference with hospital autonomy will there be"? The answer to this final question will depend partly upon the wisdom and foresightedness of hospitals in their relations with these outside agencies and partly upon the readiness of the hospitals to coordinate their activities on an area basis, according to the principles laid down in the report of the Commission on Hospital Care. If our hospitals carry out these principles, I believe their continued autonomy is assured, irrespective of their income sources.

It's a Long Way From Florence Nightingale

The current passion of nursing educators for academic degrees calls forth a protest from the author who contends that good bedside care is still the foundation for good nursing service.

M. POLLAK, M.D.
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THE aims, aspirations and professional ideals of the nursing profession have undergone revolutionary changes in recent years.

As late as in the 'thirties the nursing organizations were loud in their demand that nursing, particularly in hospitals, should be practiced only by graduate registered nurses. Institutions that employed undergraduate or practical nurses were frowned and looked down upon as operating below accepted nursing standards.

Thus, I consider it a real professional achievement when, upon taking charge of a sanatorium in 1930, I converted the nursing staff from a practical to a fully graduate one. In those long forgotten days nursing implied every procedure pertaining to the bodily care of the sick, from making the bed to handling the bedpan, as well as the care of the patient's environment in the sickroom.

But how times have changed since then! With the scarcity of nurses brought about by the war, the former standards and professional aims have been thrown overboard by the very same nurses and their organizations that formerly so ardently fought for them. All of a sudden, nurses started demanding that a sharp delineation be made between strictly "professional" procedures and that kind of menial labor which hitherto had been expected from nurses.

Yet where should the lines be drawn and who should draw them? Should such seemingly simple procedures as the making of the sick bed, the giving of the bed bath and the back rub and, above all, the handling of the bedpan be considered as professional or menial?

I did not have to wait until I became a patient in a civilian hospital during the war to become convinced that these simple and menial procedures form an essential part in the care of the sick and require the skill of a trained nurse. My personal experience as a patient only confirmed me in my conviction. Strange as it may seem to some nurses and hospital administrators, I would prefer to have my medication dispensed by a conscientious lay person who can read and have my back rubbed and bodily needs attended to by a well trained graduate nurse if I again became a patient and were permitted to chose my attendants.

After all, the dispensation of medicines requires no special skill aside from the ability to read, while the attention to the bodily needs demands skill, training and experience. True, even well trained nurses have been known to make fatal mistakes in dispensing medication. Such mis-

takes, however, were not due to lack of skill but to carelessness in reading the label.

The classification of the services to be rendered according to their appeal to the nurses, *i.e.* calling everything menial and "nonprofessional" that is unpleasant and classifying as "professional" only those duties which border on medical care, as is becoming the practice among institutional nurses these days, could lead far afield indeed, were the other professions engaged in healing to follow the same principle.

Why should a highly trained physician open a stinking abscess, treat a rectal disease or gonorrhea and not delegate it to an orderly who may acquire some skill in such procedures? Why should a laboratory technician, whose professional requirements and training are not less exacting than those of a nurse, examine the urine or feces?

Dignity Is Not Lowered

The idea that the performance of distasteful procedures lowers the dignity of a professional person is certainly foreign to the practice of the healing arts and contradicts flagrantly the traditions and experience upon which they are based. It is surprising, indeed, to see that the same procedures pertaining to bodily care which a nurse performs as a matter of course when she is on private duty are considered nonprofessional when they are required from her on an institutional staff.

Here I am not speaking of the emergency situation which all of us had to face because of the nursing shortage during the war when we were glad that we could provide any kind of "nursing" to our patients, even if we did not consider it satisfactory. I should like, however, to take exception to the present trend among nurses who advocate that the emergency solutions we were forced to accept because we could not care for our patients otherwise we now foster as standard procedures in nursing.

The present trend in nursing education has contributed its share to the dissatisfaction of nurses with the tasks demanded in bedside nursing. The fetish of academic degrees has finally caught up with our nursing educators. Student nurses are induced and encouraged to undertake a combined academic and training

course before they have given evidence that they are efficient in bedside nursing.

With all due respect to academic training, it must be admitted that it contributes little to nursing art. It also must be conceded that experience in bedside nursing is essential to the understanding of the various special problems the nurse will encounter in the diverse specialty fields of her calling.

Bedside nursing, therefore, must be retained as the foundation upon which later specialization may be built. Permitting a nurse who has never engaged in the practice of bedside nursing to become a practitioner in a special field only because she has obtained an academic degree seems just as illogical as permitting a doctor to become a specialist before he has served at least his internship in general medicine.

With our ever increasing demands in academic requirements we have not improved the quality of bedside nursing. On the contrary we have succeeded in luring our nurses away from the bedside, as a hospital administrator so aptly remarked recently.

Once again, I should not like to be misunderstood. I am not speaking against academic training as I do against the fetish of degrees. I plead that academic training be given as a postgraduate study after the nurse has attained efficiency in bedside nursing and has proved her ability in her profession. Such a program

would prepare the nurse better for her later calling and benefit the patients placed under her charge, no matter in what special field she might be engaged.

Now when the pendulum has swung back to the acceptance of practical nurses and many of our hospitals are engaged in giving some formal training to these aides, would it not be advisable to permit those aides who are graduated from high school to continue with their studies in regular training, if they so wish after they have shown their aptitude, and be given credit in relation to the length of time they have spent in practical nursing? Also, would it not be permissible under the present emergency conditions for student nurses who have shown their aptitude for bedside nursing to be graded leniently in their theoretical subjects, such as chemistry and anatomy?

Proper Care Is the Goal

After all, the most important service a nurse can render consists of the proper and adequate care of her patient. While her knowledge in the basic sciences may prepare her better to understand the theoretical background of some refined procedures, this understanding is not essential to the bodily care she is required to render to most of her patients.

If our scholastic requirements for student nurses were made to fit the needs of general bedside care and greater stress were laid on general aptitude for nursing, nurse recruitment would appeal to a wider circle of girls, I believe, than it apparently does at present. A better scholastic preparation could be demanded from those nurses who after graduation and a year or two spent in general bedside nursing wish to engage in some special branch.

It would seem incongruous to lower the general standard of patient care by entrusting it to practical nurses and at the same time keep out of our schools girls who would make excellent nurses just because they lack scholastic achievements. A critical study of our changing entrance requirements and the correlation of the effect they have had on the quality of bedside nursing practiced during the last two decades would be illuminating and instructive to all concerned, I believe

The revolution which has taken place during the past few years in the attitude of nurses toward the time honored ideals of their profession is of the utmost significance. A well known leader of nurses in the Midwest gave voice to this trend when she addressed a district meeting recently and, according to newspaper reports, stated: "It is time that we scrapped some of our traditions. We are ready for a change and a change in our attitudes. At this time *when hospitals have a greater need than even during the war and when many nurses have become dissatisfied with their work, it is time for them to become articulate,* [*italics mine*] evolve a plan and then push that plan," she advised.

To a reporter's inquiry as to how she would remedy the crucial shortage of institutional nurses, she answered sweetly, *"in a situation like this it seems to me that it is better to give fewer patients proper care than to give more patients improper care."* [*Italics mine.*]

Remember the Nightingale Oath

When the "professional" attitude is made subject to the supply and demand of the labor market, can one wonder that in these crucial days hospitals and patients are deprived of the service of nurses to an even greater extent than the prevailing scarcity would warrant? At the time of graduation student nurses may still be required to take the oath of Florence Nightingale, but in practice many of their elders have already forgotten the letter as well as the spirit of that oath.

Here would be the place to inquire how the nurses and some of their leaders got that way. Looking back on the developments of recent decades we can discern that nurses and their leaders gradually have lost sight of the fact that important as their profession admittedly is, it is still only an auxiliary to the medical profession and the hospital.

Medical and hospital organizations, on the other hand, permitted by default that nursing organizations chart their own independent course and loosen entirely the ties linking them to the former two. Thus, the present day ideals of many nurses give scant consideration to the interests of the patient. A more active stand on the part of medical and hospital organizations toward the nursing situation could do much to restore the much needed equilibrium of the triad of doctors, hospitals and nurses.

Lancet, the foremost British medical magazine, recently summarized the situation succinctly when it stated: "In the early days of modern nursing the nurse looked to the doctor for advice and help in developing her specialty, and the results of that collaboration have been an example to the world. Indeed, many of the principles laid down in that atmosphere of confidence and endeavor have stood the test of a century of nursing practice. . . . We believe that the medical profession must take a full and responsible share in restoring nursing to the position in which Florence Nightingale placed it: as an absorbing and stretching career for women with brains, as well as satisfying for women who, though not academic, are physically and emotionally apt for the care of the sick."

The "atmosphere of confidence" can be universally restored only if the differences and grievances existing at present on the part of the three groups so essential to the care of the sick are frankly discussed and a common and mutual understanding is arrived at in safeguarding the interest of the patient.

The aim of the nursing organizations in improving the economic status of their members should receive the active support of all concerned. On the other hand, only a few patients can afford without undue sacrifice the cost of a three shift working day service. By providing more than the bare necessities of care when needed, by making the widest use of group nursing and by limiting special care to those patients who are actually in need of continuous and uninterrupted nursing, hospitals could do much to spread the limited nursing supply and apportion the increased cost of nursing care among a wider circle of patients.

The increased cost in the hospital bill for the added nursing service could be borne with relative ease by the patient, and hospitals would be in a better position to adjust their salary scale to compensate the nurses for the increased cost of living. Nursing care is an essential part of hospital care. It is, therefore, the obligation of the hospital administrator to determine in what manner the nursing care prescribed by the attending physician should be provided.

Only when the judicious use of the available nursing supply is thus assured, can an unnecessary waste be prevented, the interests of all the patients of the hospital safeguarded and the economic status of the nurse improved.

Conforms With Labor Practices

The trend of organizing nurses into unions conforms to present day labor practices, when other professional groups like artists, newspapermen and teachers have established their labor organizations. Little hope can be entertained, therefore, of arresting this development. Perhaps it would be advantageous to hospital administration, too, if the necessary adjustments in the salary scales could be arrived at in the course of negotiations, provided the terms of such an agreement were just as binding on labor as they usually are on management.

It goes without saying, however, that no hospital could function properly if such excesses as strikes, closed shop and the subordination of the patients' welfare to the demands of the employes were tolerated. Nonprofit hospitals, moreover, are owned by the public, which has entrusted the management to boards of trustees which cannot be organized in any type of employer group. Thus, industrywide contracts, even on a limited geographical or community basis, are entirely out of question.

With earnest endeavor and honest efforts on the part of all concerned, and a little good will thrown in for good measure, the present critical situation in nursing could be greatly ameliorated, the patient's interests could be properly safeguarded and the economic interests of the nurses could be protected.

PEOPLE IN PICTURES

Among the presidents, secretaries and visiting dignitaries in Chicago during the midwinter meetings were, left to right: Mrs. Anne Walker, executive secretary, Midwest Hospital Association; Mrs. Ruth Barnhart, executive secretary, Texas Hospital Association; Rev. H. L. Bertrand, S.J., president of the Catholic Hospital Council of Canada; Dr. Vane M. Hoge, chief, Division of Hospital Facilities, U.S.P.H.S.; A.H.A. President John H. Hayes, Lenox Hill Hospital, New York, and Dr. Robin C. Buerki.

A distinguished family in hospital administration in California gathered at the meeting of the Association of California Hospitals. Gladys Smits, R.N., is superintendent of Santa Barbara Cottage Hospital. Her daughter Katherine (right) is superintendent of Carmel Community Hospital and a graduate of Johns Hopkins Hospital. Nephew Jimmie Smits, at left, is superintendent of Harbor Hospital at Torrance, which was recently opened by the Los Angeles County Department of Charities.

Members of the recently organized Hospital Council of Lowell, Mass., are: Front row, left to right: Lulu E. Ferris, Lowell General Hospital; Sister Angelica, St. John's Hospital, vice president of the council; Paul J. Spencer, Lowell General, president; Sister Mary Maxime, St. Joseph's Hospital, secretary-treasurer, and Ethel A. Turner, Lowell General. Back row, left to right: Thomas M. A. Higgins; Lincoln Clark; Sister Madeleine of Jesus; Sister Rita; Sister Ruth; Sister Jean; Rev. Donald A. McGowan and Rev. Leon Loranger.

He Wanted to Be an Administrator

Surprise!

He Still Does

FRANK B. ADAIR
Administrative Intern, Sydenham Hospital, New York City

ONE morning last year I didn't especially notice the fall chill that hung over New York City. What had been the sheer fascination of seeking my fortune in a brand new neck of the woods had been consummated with the prospect of launching the career I had coveted for several years. I was to begin my first day of internship in hospital management at Manhattan's Sydenham Hospital.

What I didn't know that morning was that shortly afterward—because I chanced to be the first member of my particular minority group to receive such an internship in a voluntary hospital—practically every daily in the city and most of the hospital journals would carry the story.

A Realm of Special Service

Have you ever noticed the devotion with which hospital workers go about their duties—doctors, nurses and other staff members—as if theirs is a realm of special service to mankind? I had. And now I was to be oriented in the organization and goals of these citadels which foster the highest development of medical science and restore health and happiness to hundreds of thousands of men and women each year.

When I reached the hospital my conference with the executive director began with his remark, "So you want to be a hospital administrator! Welcome to the province of a profession that knows well the taste of the brew Blood, Sweat and Tears. But if the vigil we're pledged to keep," he reflected, "is challenging and sometimes hard, it is not without its compensations; not in salary denominations capable of building family fortunes but in the special satisfactions."

As our discussion got under way I expressed surprise that the apprenticeship should be designed to cover a period of "at least eighteen months." The remark no doubt reflected a layman's misconception of the magnitude of proficient hospital administration, although I did not realize it at the time.

I was partially armed with the smugness of having already had eight years' experience in the management of institutions, some of them many times the size of the average metropolitan hospital; had "grown up in offices," as it were, from office-boy days, and had completed collegiate training in business administration and sociology, supplementing this with postgraduate work at Harvard. Could not the task of familiarizing myself with medical terminology necessary to talk budget, regulations and procedures be reasonably accomplished in a shorter period?

The director's reply was revealing. It impressed me with the fact that the task of *coordinating* the various services and adjunct services of a hospital requires a considerable period of on-the-spot training.

Sydenham provides a rotating apprenticeship. The intern is given executive authority tantamount to that of a liaison officer between the executive director and the hospital staff. Thus, he renders service to the hospital in the province of his previous training and experience while he learns requirements and procedures peculiar to hospitals.

My very first step was to get the feel of the place; to get acquainted with its departments and visit its pavilions. Then came assignments of every description. For example, when a hue and cry arose from nurses that linens were disappearing from the floors, I was asked to ascertain the source of the trouble and to put an end to it.

An investigation exposed conditions that had incorrectly placed both the laundry and nursing personnel under suspicion. The real trouble had been (1) reduction of the hospital's overall supply of linens, the result of a scarce market; (2) hoarding here and there on the part of certain nurses who at the mere prospect of shortages were making innocent efforts to protect their own supplies, and (3) temporary lags in the laundry's efforts to return linens to the floors as quickly as possible.

Complaints Diminished

As a result of the pressure placed on the personnel concerned while the investigation proceeded, the latter two conditions were almost completely alleviated. The first condition was explained at the next "gripe meeting" called periodically to iron out special problems existing between two or more departments. This reduced the tendency to complain while the hospital doubled its efforts to procure new supplies.

Another special problem arose when it was brought to my attention that the silverware was walking out of the main dining rooms in rather large battalions. Replacement bills bore out this observation and threatened to bring the wolf to our budget door for that item. The case was obviously one of pilfering.

A book record system was initiated charging the supervising dietitians on their respective shifts with the responsibility for having each piece of silverware counted as it was withdrawn and replaced daily in a central locker. This removed the temptation for dining room employes to pilfer and made them especially observant of other employes who were inclined to take silverware from the dining room for use elsewhere inside or outside the hospital. The system was installed six months ago. Silverware replacements since have been negligible.

All That Maintenance Implies

Day-to-day management procedures in the maintenance departments of the hospital impressed me with the fact that the institution must live up to all that proper maintenance implies, beginning with properly selected installations and continuing with rigid schedules of repair and upkeep. Thus, the administrative intern learns to develop the "institutional eye": the ability to detect flaws and irregularities which, though ostensibly minor, may develop into hazards that incur financial losses and severe criticisms from observers, or which may precipitate breakdowns capable of delaying a patient's recovery or endangering his life.

During my tenure that phase of the hospital that so distinguishes it from other institutions was becoming clear to me: the organization and functions of its medical staff. To enhance my comprehension of the medical and adjunct services I was given special assignments, *i.e.* to bring up to date the listings and classifications of doctors affiliated with the hospital as the medical board effected changes and as veterans returned, to prepare attendings' and interns' monthly schedules and similar duties.

These duties involve personal contacts with our doctors, special conferences with them and subsequent clearer definitions of the objectives and administrative procedures required for those of us charged with keeping the medical organization progressive, intact and on schedule. This type of activity can give confidence and reassurance to the intern in hospital administration to a degree that would hardly be attainable were the training simply so much theory.

I find that medical men rely upon and are grateful for the assistance that the administrator is especially prepared to give them, particularly his watchfulness in considering laws and regulations that control many of the activities in the hospital. Such regulations, of course, are designed to protect patient, doctor and hospital alike. Breaches can cause serious losses in finance, reputation and prestige, innocence of motive on the part of the practitioner or the hospital nothwithstanding.

I have observed that these regulations are in most instances explicit, so that the administrative intern finds his task not so much one of interpretation as of administration. Nevertheless, there are occasions which emphasize the fact that the good hospital administrator must know when to refer certain problems to the province of attorneys, and he should not hesitate to do so. Fiscal management, which includes budgeting and the interpretation of financial statements, required little modification of technics already developed in the course of previous training and experience, except for the formulation of new types of statistics ratios which form valuable bases for comparisons. However, the intern soon discovers proof that voluntary hospitals, being eleemosynary corporations, seldom exist without incurring considerable deficits. The larger the hospital's quota of indigent patients the farther will current operating revenues fall short of compensating current operating expenditures.

This free and part pay care, together with the other educational services rendered in behalf of the patient's welfare and the advancement of medical science, becomes the reason voluntary hospitals cannot operate at a profit. They must receive outside financial assistance. Thus, the obligation to continue the expansion of facilities to meet existing, ofttimes urgent, community needs—to say nothing of requirements to satisfy accrediting agencies—enhances the importance of the liberty which the hospital gives me to participate in conferences involving public relations.

They Know Their Hospitals

Finally, it seemed especially significant that in the course of several field trips to metropolitan hospitals I found that the administrators in the best managed institutions maintain a detailed familiarity with almost every square foot of their plants. Is it possible, alas, that to that formidable list of "requirements of a hospital administrator" I must add: the unalterable will to make frequent personal rounds into the wards, pavilions, laboratories, kitchens and other odd units which comprise the hospital? The "ayes" have it, it would seem!

"And you still want to be a hospital administrator?" my director asked me the other day. I answered with a hearty affirmative, reflecting that if the remaining term of my internship proves as inspiring as the last twelve months—and I have no doubt that it will—I shall feel rewarded for having entered a profession which promises to contribute a considerable share in the preservation of the nation's Number 1 Asset, its health.

Why Do They Leave? Why Care?

A Study in Exit Interview Procedure

NORMAN D. BAILEY
Personnel Director, Michael Reese Hospital, Chicago

MANAGEMENT, the representatives of administration in the persons of supervisors and department heads, speaks: "Where do they go and what becomes of them? Who cares? They're out of here anyway."

These words or others expressing similar thoughts are all too characteristic of the attitudes of employing and supervising officials toward those individuals whose employment has terminated.

Reasonably well paid, compensated also in some degree by prestige and security, it is difficult for the department head or administrator, yes, even for the personnel director, to enter into the mental processes of those employes who have decided to turn elsewhere for employment. Management must span this gulf of separation in understanding if the institution or industry is to create that best morale which builds for permanence and stability of employment. The most useful technic yet discovered for analysis of employe separations is the exit interview.

Management speaks again: "Who cares? What difference does it make?" We shall answer this time: "The attitude of the departing employe is of major significance to industry or institution." Ill will, a grudge, bitterness or misunderstanding may have repercussions difficult to measure. In the case of industry it may mean loss of trade or sales but for the institution it may mean loss of community good will. No institution, dependent in any degree upon community support, can afford even one enemy if that can be avoided without sacrifice of integrity or loss of principle.

Ill Will May Be a Boomerang

An attitude of ill will may seriously affect the employe recruiting program of the personnel department. The grapevine system works in any town or city and let it once be broadcast that the XYZ Hospital is a poor place to work, the better grade of employe will turn elsewhere. Even should jobs become scarce and the supply available exceed the demand, new employes will come armed defensively against unfair tactics of which they may have heard rumor.

Poor morale on the part of the employes has its reaction upon patients. Today we don't worry about business in our hospitals, but there may come a day when we shall be glad to have the business we shy away from at the moment.

Why listen to the gripes of those who have failed to make the grade? Perhaps we may find it worth while to listen, even to lend a sympathetic understanding, for from the exit interview we may glean much which will make it possible to prevent recurrence of problem situations. Prevention is important and, should we be able to discern some cause which may be the fault of management or which may be remedied by better supervision or some simple change in routine, we shall find that time has been well spent.

What are the technics of a successful exit interview?

1. Rapport must be established between the departing employe and the interviewer. Despite the fact that there may be some rancor in the attitude of the employe, there must be a comfortable atmosphere for satisfactory interviewing. Simple suggestions are important. The employe should be seated in a reasonably comfortable chair. The interviewer must give no indication of hurry. A low quiet tone of voice will help greatly. Under no circumstances should he allow himself to lose control of the situation by losing his temper.

2. The interviewer must conduct the interview in a place where sufficient privacy exists for the development of that aforementioned rapport between interviewer and interviewee.

3. The interviewer must recognize that in a majority of cases the reason for separation first given is not the basic reason. This may be illustrated by the case of the married woman worker who gives as her reason for separation the pressure of home cares. Further study and discussion may bring out that there are other factors: incompatibility with fellow employes and dislike of a supervisor who shifted the employe from job to job too frequently. If the other factors had been satisfactory and the working conditions excellent, the employe would in all probability have found some solution for the home problems.

Don't Force the Issue

4. Tact is essential. The interviewer must not force the issue or give evidence of an attempt to pry into the employe's private business.

5. The interviewer must be constantly on the watch to discover some casual hint in the conversation which may lead to a discovery of basic reason for separation.

6. Before conducting the interview, the personnel representative should have at hand all necessary information concerning the employe's history, the job history, the report of the department head or supervisor. With this in front of him he is ready to discuss the situation which has arisen.

7. Definitely he must not "preach." He will attempt to correct misinterpretations and misunderstandings. He will attempt to bring out the basic reasons behind established policies which may cause a grievance. He may point out that "there are many situations where the skill of the employe can be used to a real profit, but unfortunately we do not have exactly the right place to use that skill."

8. If the employe has been dismissed for flagrant violation of regulations, the interviewer will attempt quietly to discover the cause of the violations and to explain the significance of what has happened. He will not chide or scold. He may suggest that the employe will find other situations where he can start again and by avoidance of misconduct make a good record for himself. Of course, if there is any positive side to the picture he will bring it out and attempt to leave the attitude of mind that the institution has been absolutely fair.

No Effort to Retain Employe

9. Except in rare cases, by far the exceptions to the rule, no attempt will be made to retain the services of an employe who has decided to leave. While there is much controversy and difference of opinion on this point, experience seems to indicate that it is better to use the exit interview to prevent recurrence of unfortunate situations than to bring pressure on employes who have already decided to leave. Reasons for this are evident.

The employe who remains against his will is always shadowed by the thought that his opportunities would have been greater had he moved on to greener pastures.

The morale of the employe group as a whole is not improved by the thought that one employe has been singled out as of greater value than many others. This is especially true if privileges of a special nature have been granted to retain the services of the employe. (Note: About this time look for a procession of employes toward the personnel office seeking some form of special privilege for themselves.)

10. A record should be kept of each interview, but entries should be made on the record form at the close of the interview rather than in the presence of the employe. The separation of entry and interview will aid greatly in establishment of the desired rapport.

The exit interview should be conducted by a member of the personnel department staff, preferably one who knows the work history of the employe in question and the general picture of the working situation in the department in which the employe has been located. Certainly, the interviewer must be one who understands the technics and purposes of the exit interview.

The question is asked as to why the interview may not be conducted by the department head. The answer is that the approach of the department head to the problem is necessarily subjective, both as regards his own conduct of the program and as regards the departing employe. Because of his own direct part in the situation the attitude of the department head may even be defensive or antagonistic. The personnel department, somewhat removed from the immediate problem, is more likely to be objective in its approach.

Occasionally some self sufficient and conscientious department head or supervisor feels that the exit interview is trespassing on his private domain. This is because there has been somewhere a failure to give a real preview of what this technic can do to help management. Some mistaken concept of its use as a scheme for getting "behind the scenes" information has been accepted as fact by the supervisor and the real values have been lost from sight.

Good exit interview procedure does not tend to put the supervisor on the spot. Instead, the interview may do much for him. It may show him weaknesses in his department which he can correct before recurrences cause him to be criticized. It may help him to realize that the cause of separation is nothing he could help but is rather a problem which affects the institution in general and which must be met by top administration.

The supervisor may discover personality conflicts which can be eliminated by rearrangement of work. He may find that his program of induction to the job needs revision in the light of a change in type of employe. All in all, if the department head and supervisor are taken into confidence, there will be a general reevaluation of phases of work activity and progress all along the line.

No one can lay down a specific pattern and say to the interviewer: "This is the way." Among his prerequisites must be insight enough to enable him to suit his approach to the situation as it develops. That innate ability to size up a problem, to sense the hidden factors and to help him see the whole picture is a valuable asset. No amount of training can replace it. Granted this, experience will be the best teacher. There is always danger of lapsing into that state of mind in which one is content to scratch the surface and to leave undone the more difficult task of analysis.

What the Hospital Gains

What can the hospital gain from the exit interview? Unless there are worthwhile gains to be realized through the time spent in talking with the departing employe the interview becomes merely another record keeping procedure and the time and effort are wasted. Well conducted interviews should have as minimum goals these ends:

1. The establishment of good will in the mind of the employe who is leaving.

2. Discovery of basic causes of termination, whether these causes lie within or outside the organization.

3. A sidelight on problems of employe morale which, while not major causes, may be contributing factors. If such causes turn up in a number of cases they should be reason for investigation.

Discovery of basic turnover causes outside of the organization may indicate the need of some new screening procedure in selection. To illustrate this: It may be found that for certain employes who go to work at early hours there is a real attendance problem owing to poor transportation facilities. This may lead to an attempt to obtain better transportation or to eliminating from consideration for employment individuals who have to depend on existing means of transportation.

A second illustration might be found in analysis of age level and turnover. This analysis in the exit interview and in the responses given by the employe may lead to some age level screen for applicants.

A third illustration would be in the relationship between education or intelligence level and job holding power. Study may show that in our attempts to obtain the "best" employes for certain routine jobs at a level involving monotonous repetition we are "hitting too high," and whereas a person with less education might be content, the individual with a high I.Q. becomes bored and quits after a brief term of employment.

4. Revelation of the necessity for reevaluation of certain positions where excess turnover is marked.

5. Recognition of unusually desirable situations. Too often exit interview procedure is thought of as related to unsatisfactory relationships. Many times the departing employe is leaving for reasons which cast no reflection on the organization and from the exit interview we should be able to gain suggestions as to superior employe-supervisor or working situations from which we may profit.

An illustration of this is seen in an exit interview held with a young college student who had worked during the summer vacation as an orderly. His contact with a hospital working situation had given him real help in making a vocational choice. For the opportunity given him he was especially appreciative—good induction, good training and good employe morale were all indicated.

6. Discovery of weaknesses in the employe job induction and training program. Recurrence of turnover at the end of a short period of employment is usually significant in this respect.

At the end of each quarterly period an overall study of turnover may well be carried through by the personnel department. The results of this study, as well as the details of each case, should be available to department heads and the administrator.

"What do we care?" A little care may mean a great deal to us in the hospital field if we will but think of it in terms of the ultimate as well as the immediate results. Care and consideration for the departing employe may mean community good will; a decreased turnover with accompanying financial saving; better employe morale and stronger loyalty in the institution, and better employe selection and training. It will accordingly find its parallel in better patient care, which, after all, is our reason for being.

Opportunities in Community Health

SIDNEY M. BERGMAN
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MANY opportunities in public health lie within the province of any hospital, inasmuch as even the small community hospital should be enabled by coordination and affiliation to obtain for the people it serves the advantages to be drawn from great medical centers.

In the ideal hospital which we shall project here, the policy forming body, the administration and the professional staff are in accord with the principle that all of the community is entitled to comprehensive medical care. This hospital is, of course, equipped to give its patients the benefits of the latest methods in diagnosis and therapy. Not only has provision been made for the treatment of acute medical and surgical conditions, but a section has been set aside for communicable diseases so that these patients are not dealt with as a pariah group, and nurses and young physicians can develop experience and facility in the control and treatment of diseases which can become epidemic.

Beds also are available for neuropsychiatric disorders, so that patients who are transiently ill can receive care without the stigma of institutionalization. Neither is the patient with tuberculosis held in disfavor. Recent developments in chest surgery demand provision for these patients in the general hospital.

The lengthened span of life has accentuated the problem of the so-called degenerative diseases. Facilities for the care of chronically ill patients generally are woefully inadequate or lacking altogether. A survey of the inmates of a custodial institution recently showed that 65 per cent were in need of hospitalization as long term patients. Some of them indeed might be capable of marked improvement as the result of good hospital care, and some might conceivably get well instead of being doomed to the abandonment of hope implied by custodial gates. Certainly, beds for the chronically ill belong in a wing of our ideal institution.

To complete the inpatient program we can well pattern after the rehabilitation program of the army air forces. This implies early and planned convalescence in which the patient on the day following surgery or the first day of normal temperature following acute illness is beguiled into accelerated recovery by the combined efforts of his physician, the physical therapist, the occupational therapist and the social worker. By this means the patient's stay is shortened and readmissions are reduced.

More important than the inpatient department is the outpatient department, inasmuch as it deals with incipient disease and preventive measures. Perhaps in its future planning thought will be given to the establishment of group practice by the professional staff of the hospital. The pattern set by leading diagnostic clinics associated with university hospitals in providing patients with the benefits of group diagnosis by teams of specialists accustomed to integrate their findings in the consideration of

Condensed from a paper presented at a meeting of the Federation of Social Agencies of Pittsburgh and Allegheny County.

the patient as a whole might well be considered as worthy of emulation by hospitals that are more remote from teaching centers.

In the outpatient department the linking of preventive medicine with curative medicine in a common effort can logically occur. Here the voluntary health agencies of the community can establish branch offices or, indeed, in the small community can find their headquarters. Such cooperative effort would tend to demonstrate clearly instances of overlapping and would pave the way for greater efficiency in organization. Unmet needs would similarly be made obvious.

Would Work With Health Agencies

Our projected outpatient department would include a prenatal clinic, an obstetrical clinic and a postpartum clinic, all associated with the obstetrical service of the hospital. This service would naturally work in close cooperation with the maternal and child health bureau of the local health department. The aims of this joint effort would be to determine which sections of the city were suffering from high incidence rates and through a joint attack involving a better health program for mothers, including mental hygiene, to strive to bring about the elimination of the causes of the high mortality rate.

A well baby clinic, a preschool and pediatric clinic, perhaps bolstered by a child guidance clinic, would integrate with the pediatric in-service. Logically, here, too, the communicable disease prevention program in the community would receive due attention.

In addition to medicine and surgery and their allied specialties, a tumor clinic organized in accordance with the requirements of the American College of Surgeons would cooperate with the health agencies in the early detection and prompt treatment of cancer. The heart clinic, urological clinic and metabolic clinic would function similarly in a program of study and reduction of the degenerative diseases.

The establishment of a food clinic would bring to the ambulatory patient the latest benefits of diet in the maintenance of normal health. To implement the prescription of the physician, the dietitian would here explain to the patient, with the aid of illustrations, food models and actual food preparation, the elements of a suitable diet in terms of the patient's racial and economic background. Thus, a patient accustomed to a foreign diet and handicapped by a submarginal income would have translated to him in terms of that diet the optimum intake in proteins, fats, carbohydrates and vitamin content to meet his physiological requirements.

Mental hygiene, psychosomatic and neuropsychiatric clinics would function in their preventive aspects supported in the knowledge that cases could, should need arise, be referred to an established service in the hospital, a necessity which is too frequently lacking.

The presence of well organized medical social service would supplement and intensify the effectiveness of these many services and serve as a link between the family agencies, the governmental and private relief organizations and the needs of the hospital patient. Particularly in the venereal disease program and the tuberculosis control program the social service worker's contribution in bringing medical resources and health knowledge to the level of the individual and his family cannot be overestimated. Because the medically indigent patient has no monopoly on environmental and emotional problems, the services of the skilled medical social worker would also be made available to the private patient, perhaps on a fee basis.

The x-ray department of the hospital would provide the outpatient service with a fluororoentgen unit so that all admissions and all personnel would be routinely surveyed. The detection of incipient heart ailments, as well as early tuberculosis, would be an essential contribution to community health. In the small community this service might well be universal.

A follow up clinic in the outpatient department would maintain a liaison with the discharged inpatient and continue supervision as long as necessary while, conversely, an extern service functioning with the district nursing organization would afford domiciliary care in many situations where prompt intervention would make the utilization of hospital beds unnecessary. This follow up service would, of course, cooperate with the health department with particular reference to tuberculosis and venereal disease control.

Health education should be centered in the outpatient department; visual demonstrations in the form of displays or motion pictures, discussion groups, health talks, extramural lecture programs in schools, clubs and other organizations, all must combine to bring to as many people as possible the message of healthful living.

Program Is Not Too Ambitious

While this program may seem ambitious it is the failure of our present programs to meet the need that is to be deplored. We may take cognizance of the medical advances which have come out of the holocaust of the recent great war. Military necessity compelled action where in peace time the humanitarian aspirations of proponents of health had failed, as witness the pooling of the scientific resources of the nation in the National Research Council. Coordinated effort and abundant funds served to stimulate research out of which came methods and technics that were given mass application under controlled conditions by the medical departments of the armed forces. The superb results obtained are a demonstration that requires no accentuation.

We have only to look to the concerted efforts in the investigation of atomic power, which as a by-product has already supplied several potent weapons to medical science, to find the key to the solution of unmet health problems of the future. By coordinated, well integrated effort as a united people we can be spared the annual Hiroshimas visited on us by the still unsolved problems of disease.

SMALL HOSPITAL FORUM

In Case of Emergency

Every hospital has its own problems and the greatest of these is SPACE

THE number and nature of emergency cases handled in a small hospital depend, of course, upon the nature of the area it serves. Hospitals with the same number of beds in towns of about the same size may have entirely different emergency problems, owing to differences in industrial and transportation conditions and the nature of the population.

This observation is borne out by the fact that in a group of hospitals in the same bed size classification covered by a Small Hospital Forum on emergency facilities the number of emergencies handled varies from as few as 60 to as many as 4000 cases a year.

Number and Space Not Correlated

Obviously, most hospitals now operating were not designed in accordance with careful surveys of the type of problem presented by the community. This is apparent in the emergency facilities available at the hospitals covered in the survey. There is no correlation between the number of emergencies handled and the space available for emergency treatment.

For example, a hospital that received only 70 emergencies during its last fiscal year has an emergency suite consisting of a waiting room, examining room and treatment room, whereas another in the same group treated more than 4000 cases in a single, all-purpose emergency room, and several hospitals whose emergency admissions run into hundreds annually have no space at all adapted to this specific use.

In fact, eight out of 23 hospitals responding to this forum have no emergency department as such. Emergency cases in these hospitals are taken directly to one of the operating rooms for treatment. "We have an emergency room located beside our ambulance entrance," the administrator of one of these hospitals explains. "Because of the shortage of help, however, this room has not been used in recent months. Instead, patients are taken directly to the minor operating room, where a nurse is always available. We would prefer using the emergency room, but it just hasn't been possible."

Several hospitals have a combination examining and treatment room for minor injuries and illnesses and send the more complicated emergencies directly to the surgical department. Among these 23 hospitals, only eight have emergency departments consisting of more than one room.

Eighteen of the responding hospitals indicate that relatives, police and other visitors are not permitted to enter the emergency treatment area. Four of the hospitals do not have such a rule and acknowledge that relatives and others "occasionally" are admitted to the treatment or emergency operating room, depending upon the nature of the case. One of the hospitals in the group did not reply specifically on this point.

In addition to the eight hospitals that have no emergency facilities as such and transfer all emergency admissions immediately to the operating room, most hospitals apparently make a practice of taking the more serious cases directly into the surgical department. The percentage of emergency admissions handled in this fashion again varies with the number and nature of emergencies treated.

In only one or two cases are all patients admitted to the emergency department treated without removal. In most cases the distinction is one of gravity, and the number of patients removed before treatment is undertaken is not stated.

Assigning Cases to Staff

About two thirds of the hospitals participating in the forum have a rotation system for assignment of emergency cases to staff doctors. Four hospitals indicate that assignment is made haphazardly, with no particular system prevailing. Sixteen hospitals have a rotation plan of one kind or another, usually with one doctor taking these calls for a week or a month at a time.

In one case, patients admitted during the day are treated by any staff member who happens to be around at the time, and the rotation plan obtains only for night admissions. In another case, a resident physician handles all emergency admissions. It is stated in several cases that, whenever possible, the patient determines who the doctor is to be.

In the case of eight of the responding hospitals, every member of the attending staff participates in the rotating emergency service. In three cases, the reply indicates that rotation is limited to those who have specifically requested emergency assignment. In two additional cases,

the rotation is limited to doctors living in the vicinity of the hospital who are quickly available at all times. In only four cases does the staff require that emergency service be limited to those with special training.

More than half the participating hospitals do not require that nurses serving in the emergency room have special training in first aid care of accident victims. In four cases, some provision of this kind is sought through the assignment of surgical nurses only to emergency service. Four hospitals require that emergency room nurses have specialized training.

In six of these hospitals it is the established rule that no treatment of any kind be undertaken until the attending staff doctor arrives. Thirteen hospitals permit the nurse in attendance to undertake initial steps of treatment, five of these specifying that this is done only when the emergency is extreme. Two more in this group indicate that such steps are taken only when the nurse has consulted the doctor by telephone and received specific orders on what to do, and another hospital adds that the nurse may administer drugs but may not take any other treatment steps.

The extent to which others are permitted to go is indicated in the following explanation received from another hospital: "In the doctor's absence, the surgical nurse has instituted treatment, such as the administration of plasma, intravenous solutions and burn dressings. She has also ligated bleeders and delivered emergency obstetrical patients."

Admitting Communicable Cases

Is Principally a Matter of Preparation

MARY E. PILLSBURY
Albuquerque, N. M.

WHAT is entailed in the admission of the communicable disease patient to the general hospital? For the fact must be faced that with the shortage of hospital beds and the ever present threat of epidemic, the general hospital must be prepared to open its doors to these patients.

This shortage of hospital beds and the realization that the general hospital must soon do something about the care of communicable diseases are clearly stated in the report of the Commission on Hospital Care following a two year study of hospital needs in the United States, made under the auspices of the American Hospital Association (1946).

This report states that some 195,000 more general beds are needed to serve the American people adequately and that general hospitals should arrange to care for certain of the communicable diseases, including polio. The report further states that the special communicable disease hospitals now operated by cities, counties and states should be either abandoned or expanded to care for other types of illness.

The first step in the admission of communicable diseases to the general hospital is an understanding on the part of those who formulate institution policies of the nature of these diseases and a confidence in the ways and means set up in the hospital to prevent their spread. Second, a survey should be made of the number of beds and of the bed space that can best be allocated to them. Third, each hospital should have in effect, at all times in the care of all patients, a technic of medical asepsis upon which to build the rigid technic used in the care of the communicable disease patient.

The keynote, therefore, is preparation: preparation in attitude, knowledge and confidence; preparation through planned space, and preparation through the establishment of medical asepsis.

Preparation in Attitude. While on a trip through the country during the recent epidemic of poliomyelitis a successful business man who was a director of a general hospital told me that neither he nor any member of his family would take one step inside the hospital if a case of polio were admitted! The same attitude is often taken toward the admission of chest tuberculosis. Yet almost all general hospitals routinely admit such other communicable diseases as typhoid fever, meningitis, encephalitis and septic sore throat.

These patients are placed on "isolation" and protective barriers are set up to prevent the spread of the disease. The causal organism is attacked at the source by concurrent and terminal disinfection. The use of gowns, hand scrubs and masks prevents the spread of infection. The same barriers are as effective in the care of polio and chest tuberculosis as they are with these other transferable diseases. Why, then, this reluctance to admit them to the general hospital?

It may be that there still persist an aura of fear around polio and a lack of confidence in the ways and means set up to control its spread in the hospital. That this fear is unfounded has been proved in the most recent epidemic.

Massachusetts General Hospital turned over one section of single rooms to children and adults suffering from poliomyelitis. Unit equipment was supplied and it was staffed and cared for according to the usual communicable disease setup. In reporting on the unit, Dr. Nathaniel Faxon says: "No instance of infection of another patient, doctor, nurse or any member of the hospital personnel has been recorded here."

Three other general hospitals that successfully admitted polio were Elizabeth Coffee Memorial Hospital of Florence, Ala.; Children's Hospital of Buffalo, N. Y., and Meadowbrook Hospital of Hempstead, L. I.

In New York City, Knickerbocker Hospital turned over one floor formerly used for pediatrics to the admission and care of polio cases, both children and adults. This unit is complete in itself. There are single rooms for the isolation of cases when they are in the communicable stage. Patients are considered noninfectious after the temperature has been normal for forty-eight hours. At that period all precautions are lifted, except against the outside visitor who is gowned as a protection for the patients.

Contamination No Longer Feared

When this unit was first opened, there was some fear that the nurses and attendants might transmit the disease when they went to the common dining room for meals or even when other hospital personnel met them in the elevator. After a short time, that fear disappeared and no one is concerned that a floor devoted to the care of polio is housed in the same building in which a general hospital operates!

All three hospitals named came to the same conclusion, *i.e.* that the general hospital should and can safely admit polio patients. It was discovered further that the general hospital census was in some instances greater than normal, excluding the polio census, and that there was apparently no shunning of the hospital by the public because of the presence of these cases.

In regard to chest tuberculosis, Dr. Herman E. Hilleboe, then chief of the Tuberculosis Control Division of the U.S.P.H.S., said in 1945: "Most general hospitals state that institution policy does not permit the admission of known tuberculous patients, particularly if the chest disease is the primary cause for hospitalization."

Municipal and university hospitals have established isolation units for the care of these patients but only a few of the general hospitals have followed this practice.

Even if there is no ward available, the patient can safely be cared for in a single room. The function of the general hospital is that of diagnosis and treatment. The sanatorium would continue to care for the long term case. It would appear, then, that while the general hospital freely and willingly admits certain of the communicable diseases, its policies exclude the admission of others.

A change in attitude is the first step in preparing for the admission of the communicable disease patient to the general hospital.

Preparation With Plan. Each hospital should make a survey to determine the space best suited for the care of communicable disease patients and the number of beds that can be set aside for their use in the event of an epidemic. For many general hospitals it would be costly and impractical to set aside even a few rooms the year round solely for the use of communicable diseases. No hospital should be expected to keep beds or space available for possible use at a future date.

As a matter of fact, it has been suggested that isolation hospitals which have empty beds during seasonal off-periods admit general cases. All hospitals, large and small, can be ready with a plan that can quietly be put into operation without the necessity for hurried conferences and special meetings. Even one case admitted is a service to the community. One ward will be a haven to the stricken!

Elizabeth Coffee Memorial Hospital turned over a ward to polio cases and, because of the need for every bit of space, treated the entire room as one unit. A hospital that has such a definite plan is prepared to meet an emergency and has taken the second step in the preparation for the admission of communicable disease cases.

Preparation Through Practice of Medical Asepsis. Cleanliness is the underlying principle of medical asepsis. These technics call for: (1) washing the hands before going from one patient to the next; (2) wearing short sleeved gowns and uniforms and omitting the use of wristwatches and rings; (3) providing individual equipment for all patients, and (4) considering the floor throughout the hospital to be contaminated.

These procedures form the foundation of the rigid technics for the care of the diagnosed communicable disease. The nurse who has formed this habit of cleanliness in her daily care of the general patient easily and safely adds the gown, the hand scrub and the concurrent and terminal disinfection required for the care of the communicable disease patient.

There is little chance of any slip in technic by a nurse so trained. Moreover, medical asepsis acts as a protection during possible exposure to an unknown case. All that is necessary to establish the technics of medical asepsis are thorough teaching, careful and constant supervision and the availability of running water in all rooms and wards.

Shift Can Easily Be Made

With nursing of this kind in effect, the shift to the rigid technic necessary for the care of polio, typhoid fever, chest tuberculosis and other communicable diseases is made easily and safely. The trained soldier is merely moved from the line of prevention to the line of defense.

What of the added cost to the hospital? Almost all hospitals are now equipped with running water in the wards and rooms. Almost all general hospitals now care for some of the communicable diseases and therefore have a supply of gowns. Running water and gowns form the essential equipment for the care of these patients. Extra nurses may have to be assigned to some patients during the acute stages of the illness. This, however, is also true of the very ill postoperative patient. Putting up of cubicles is necessary only when added bed space is needed. The few cases in the small hospital can safely be cared for in single rooms or wards, depending upon the nature of the disease.

What does the hospital gain through admitting the communicable disease patient? By rendering this additional service to the community valuable experience is gained for its doctors and nurses and the hospital takes its real place as a builder of health.

ABOUT PEOPLE

Administrators

Charles A. Wordell, superintendent of the Children's Hospital, San Francisco, and the first president of the American College of Hospital Administrators, died suddenly on February 14 after just having attended the annual meeting of the Association of California Hospitals in Santa Barbara at which time he was elected treasurer of the association. Less than a year ago he completed a term as president of the same association. Mr. Wordell had also served as president of the Illinois Hospital Association and the Chicago Association of Hospital Administrators and had held many other offices.

Before going to San Francisco, Mr. Wordell was superintendent from 1929 to 1941 of St. Luke's Hospital in Chicago and prior to that was superintendent of St. Luke's Hospital, Denver, from 1921 to 1929. He was also an active member of the American Protestant Hospital Association.

Mr. Wordell and **J. Dewey Lutes** were the two first officers of the American College of Hospital Administrators but Mr. Wordell did not complete his term, which was completed by **Robert E. Neff.**

Fred J. Loase, a fellow of the American College of Hospital Administrators, resigned as administrator of Presque Isle General Hospital, Presque Isle, Maine, on March 1. Mr. Loase, whose son is the assistant superintendent of Tampa Municipal Hospital, Tampa, Fla., plans to make his home in St. Petersburg, Fla.

Rev. Armour H. Evans has assumed the position of assistant to **Dr. H. L. Gleckler,** superintendent of Wesley Hospital, Wichita, Kan. The Reverend Mr. Evans has just completed the course in hospital administration at Northwestern University. He served as an army chaplain from 1942 to 1946 and was discharged with the rank of captain.

Frank C. Haythorn, who has been business manager of the Healthwin Hospital at South Bend, Ind., began his new duties as assistant superintendent of Greenville General Hospital, Greenville, S. C., on March 1.

Russell T. Nye has taken the position of administrator of Northwestern Hospital, Minneapolis, effective February 15. For the past several months Mr. Nye has been resident director of the Los Angeles County Survey for James A. Hamilton and Associates. Prior to that he was for a number of years administrator of the Dallas City-County Hospital System, Dallas, Tex. Mr. Nye is a graduate of the University of Chicago course in hospital administration and is a past president of the Dallas City-County Hospital Council and of the Texas Hospital Association.

Mrs. Walter Aschenbeck has assumed her new duties as business manager and general superintendent of Caney Valley Hospital, Wharton, Tex.

Mrs. Ona B. Brown recently succeeded **Mrs. Edna Benson Gordon** as superintendent of Physicians' and Surgeons' Hospital, Corsicana, Tex.

Roy H. Giese is the new manager of La Grange Hospital, La Grange, Tex., succeeding **Mrs. A. K. Guenther,** who had been associated with the hospital for twenty-five years.

Paul Cushing has been named administrator of City-County Hospital, El Paso, Tex., replacing **Col. George W. Cook.** Mr. Cushing's resignation as head of Providence Memorial Hospital in El Paso was reported in these columns recently.

Elise I. Biechler is the new administrator of Westlake Hospital, Melrose Park, Ill. Miss Biechler was a member of the first graduating class of the hospital administration course at Northwestern University, Chicago.

Dr. Montgomery Blair Jr., who served as chief of medical service with the 220th and 297th General Hospitals in the European Theater, has been selected as director of Children's Hospital, Washington, D. C. Dr. Blair had practiced pediatrics in Washington from 1930 until he was commissioned a major in the army medical corps in 1942. Immediately following his discharge from the army in 1945, he was appointed to the executive staff of the American Academy of Pediatrics Study of Child Health Service, from which he resigned to head Children's Hospital.

Sister M. Stanislaus, formerly administrator of St. Joseph Mercy Hospital, Sioux City, Iowa, has been transferred to a similar post at St. Joseph Mercy Hospital, Mason City, Iowa. Her successor at Sioux City is **Sister M. Dorothy,** who was the former incumbent at the Mason City institution.

Vincent A. Walker and **Helen Newman Synnett** have been appointed administrative assistants at Samuel W. Bowne Memorial Hospital, Poughkeepsie, N. Y. Mrs. Synnett is in charge of food management at the hospital.

C. K. Shiro, administrator of Spartanburg General Hospital, Spartanburg, S. C., for the last three and a half years, has submitted his resignation to take effect on March 31.

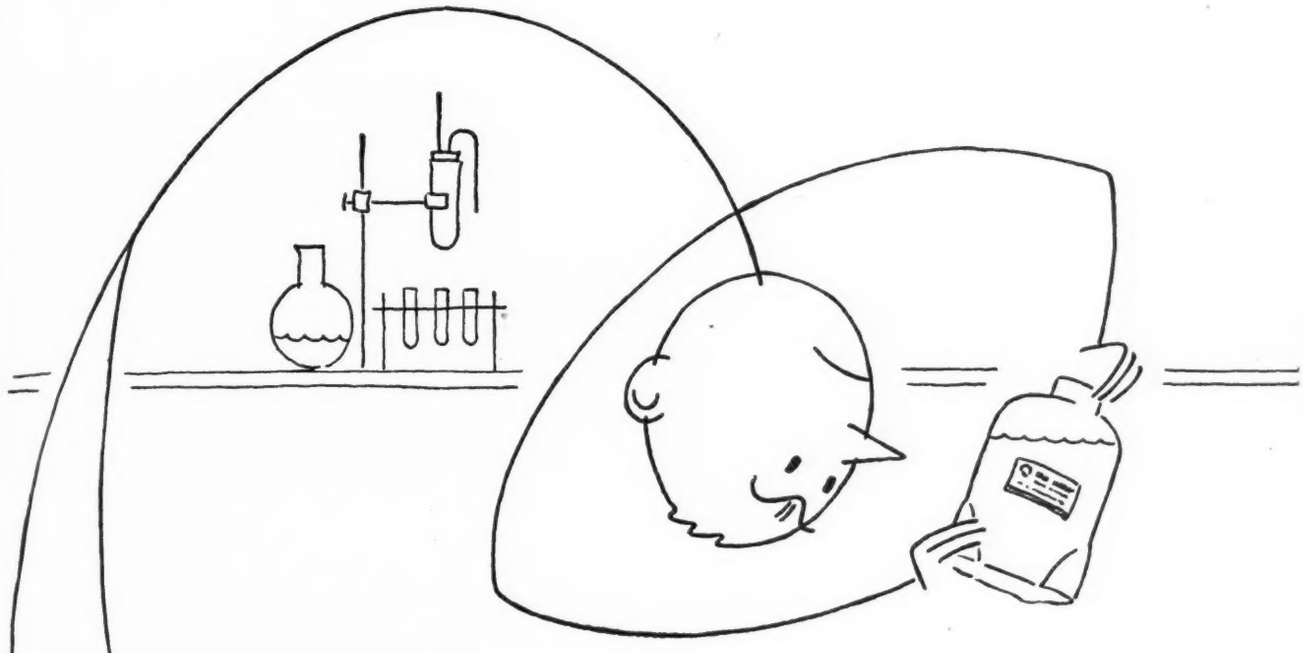
Other resignations from the hospital announced at the same time are those of **W. H. Smith,** business manager, and **M. H. Shealy,** purchasing agent. Mr. Smith has accepted the superintendency of Scotland County Memorial Hospital, Laurinburg, N. C., and Mr. Shealy has taken the post of superintendent of Cherokee County Hospital, Gaffney, S. C.

Richard T. Viguers has assumed his duties as administrator of Joseph H. Pratt Diagnostic Hospital, a unit of the New England Medical Center in Boston. During the war, Mr. Viguers was a major in the medical administrative corps of the army. He served in India with various hospital units and was executive officer of the 5000 bed Brooke Convalescent Hospital at San Antonio, Tex. Prior to his army service, Mr. Viguers had been with the Commonwealth Fund as an associate in the Division of Rural Hospitals and had been administrator of Bound Brook Hospital, Bound Brook, N. J. He served his administrative internship at St. Barnabas Hospital, Newark, N. J.

Dee Elsome, R.N., has resigned as superintendent of Passavant Memorial Hospital, Jacksonville, Ill., after twelve years of service. Miss Elsome is a former trustee of the Illinois Hospital Association and a member of the A.H.A. House of Delegates.

Sister Bathildis is the new Superior and administrator at St. Mary's Hospital, Quincy, Ill., succeeding **Sister Ferdinand,** who was transferred to Cincinnati.

(*Continued on Page* 172.)



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TRUSTEE FORUM

CONDUCTED BY RAYMOND P. SLOAN

Interpretation Is the Modern Concept of Hospital Stewardship

RAYMOND P. SLOAN

THE original concept of a good trustee, according to voluntary hospital history, was a citizen of renown who fought valiantly for the survival of his individual institution. Not fire, war, famine, pestilence or even doctors' riots could deter him from keeping open its doors to serve suffering humanity.

Scarcely an institution which could not boast one or more such heroes. Their great contributions form the backbone of voluntary hospital service in this country today. Their rule was absolute, powerful and undemocratic, contributing to high distinction on the one hand and mediocrity on the other. They were isolationists in their hospital thinking and planning, each institution being a power unto itself and operated without relationship to other health and hospital agencies.

Public Not in Their Confidence

The fact that for many years the government of our voluntary hospitals has been in the hands of individuals who possessed the resources and the willingness to finance them made it unnecessary to take the public into their confidence. Without the pressing need to interpret hospital service the public remained uninformed.

The public still is uninformed by and large; it still lacks proper interpretation of voluntary hospital service, yet during recent years we have witnessed a cataclysm of world affairs during which our hospitals have to larger degree than ever before been turned over to the public. Voluntary hospitals have gone where they belong—to the people. No longer are they the responsibility of the few, but the responsibility of their communities. Group thinking, group planning and group action must guide their destinies from this point on. The day of isolationism has passed.

The question remains as to how we can interpret hospital service to the public in such manner that it can intelligently judge. How can we bring before it and keep before it the changing health picture and the part that the hospital must play in it?

To interpret we have need of interpreters and this is, or should be, the modern concept of hospital stewardship today—interpreters, men and women of the people who are sufficiently acquainted with the problems involved and their various implications to interpret them to others; men and women who see the situation not through the doors of their own institutions but as members of hospital and health agencies engaged in developing an all embracive program to meet the needs of that community.

Unfortunately, we must make up for our deficiencies of the past. We lack sufficient numbers of trustees who are qualified to serve as interpreters. Because of the rule of the few, the knowledge of the many has been overlooked. The boards of our hospitals have been glutted with those who have been content to sit by and watch the proceedings rather than get in and push.

To compensate for this lack of knowledge, greater emphasis during recent years has been placed upon trustee education. Surely this is needed, but let's drop the word education. It has a smug, holier-than-thou implication. Instead, let's use the term "trustee interpretation." The trustee should be so informed that he, in turn, can interpret hospital service to the community of which he is a part.

How is this to be accomplished? One of the major functions of the hospital administrator is to serve as interpreter not only to the board but to the staff and to the personnel so that everyone actively identified with hospital affairs can speak, and speak intelligently, on its multitudinous problems. Through such proper interpretation the trustee will be guided in his deliberations and discussions on various hospital problems. He will be able to answer more intelligently such questions as the following:

Is the hospital actually going to serve as a general hospital and health educational center for its community? If so, is it going to consider the needs of providing an all-embracive health care program including provisions for long term illness, geriatrics, convalescence, communicable disease, nervous and mental ailments and tuberculosis?

Does It Have a Teaching Program?

To what extent will it be a teaching hospital? I do not refer to an affiliation with a medical college necessarily, but to a carefully formulated program of education for its professional staffs, in-service training for its mechanical staffs and a program of education for the public.

To what extent will it practice preventive medicine? Will its program be keyed to group medical practice and will offices for its doctors be provided under the same roof? What provision will be made for research, for housing public health activities?

What about the nursing situation? Should the school, if one exists, be expanded and, if so, to what extent? Or should it be eliminated altogether? What type of nursing does the community require and in what quantities? Does the so-called practical nurse or nurse attendant fill a real need not only in the hospital service but in the community service? And how far can we go in meeting nursing demands for higher salaries and shorter hours?

Presented at the American College of Surgeons meeting, Cleveland, 1946.

Who is going to establish and maintain the policies of our voluntary hospitals: groups of doctors or the board of trustees? The sooner this question is answered the better for all concerned because too many institutions are floundering today pending such decisions.

Is the trustee actually going to assume responsibility for maintaining proper medical standards? Is he going to take seriously the question of who is or who is not permitted the use of the operating room? Is he going to think twice and possibly do some investigating of his own before saying "yes" or "no" to the appointment of a staff member?

What will be his attitude toward the medical record room and staff audits? Does he stop to realize that the record room provides evidence of the extent to which the hospital has fulfilled its obligation to the patient? Certainly a business man recognizes the importance of audits in his own organization. It is all the more important in dealing with life and death to gauge professional activities through routine use of the staff audit.

Personnel problems have confronted hospitals in recent years. Labor leaders have stepped in and advanced certain challenges which should have been made and met within the hospital group many years ago. Unquestionably, here is something in which every trustee should become interested to the point of asking questions and finding the answers.

Hospitals at the Bottom

A study of hospital salaries as compared with those of similar institutions should prove informative. And this might well start with the salary of the administrator and work down. It would also be enlightening to discover how wages paid in certain hospital jobs compare with those paid for similar service in other lines. It might be illuminating to the trustee to discover that in almost any employment agency hospitals are at the bottom of the preferred list. Why? Because wages have been poor, hours long, the work hard and the living and housing, where they are included, inadequate.

What can be done to make hospital work more attractive? We know that many nurses returning from service are loath to go back to their hospital posts. We know that dietitians are deliberately veering toward industrial work and state nutritional opportunities. What can be done about it?

One thing can be done most assuredly. Each and all of us want security, we want some protection against retirement and old age. Some hospitals have already provided a retirement plan for their employes. It is to be hoped that many more, in fact, that every such institution will take advantage of the retirement plan designed particularly with hospital needs in mind that the American Hospital Association has developed in conjunction with the National Health and Welfare Retirement Association.

Are we going to continue to receive, and expect in greater proportion, help from the federal government in the field of health and, if so, where will this lead us? Certainly, this constitutes a definite challenge to voluntary enterprise.

With hospital and nursing costs rapidly rising and with increasing demands for free hospital care because of higher living costs, our hospitals are faced with the challenge of procuring the necessary financial support to carry on. It is a generally recognized fact that in many states rates paid to voluntary hospitals by state, city, county and township welfare departments for indigent patients are completely out of line. In some instances they haven't been revised for ten years or more.

The cost per patient day may be $8 or more, for which the hospital receives as low as $3.50 or $4.50. The trustee should be informed of the unfairness of this procedure and make his voice audible with others in pleading the cause of the voluntary hospital to obtain from government compensation more nearly commensurate with the cost of caring for the indigent. Our hospitals cannot afford to care for increasing proportions of their patients at a figure that represents anything less than complete cost.

On the horizon we see nonprofit, prepayment hospital and medical plans playing an increasingly important part in meeting the health needs of the people. It has been said recently that voluntary insurance plans, including those of insurance companies as well as those of Blue Cross organizations, are paying the hospital bills of between thirty and forty millions of our people currently. Yet Blue Cross has its problems for which remedies have yet to be found. Is the trustee posted on what goes on? What part is he playing in discussions on payment for Blue Cross services, control of Blue Cross management? Is he qualified to express himself? If not, why not?

Having gained a proper interpretation of these and other pressing problems, the trustee will be ready to share his knowledge with the community of which he is a part. He will recognize that the policies that governed our hospitals of 25, 50 or more years ago do not hold today.

He will look about him and appraise skillfully, shrewdly and with knowledge. Hospital trusteeship involves definite obligations, each member of the group being given a rôle to play with the understanding that he will play that rôle to the best of his abilities.

Need for Group Action Apparent

The trustee will recognize the necessity for group planning through closer cooperation with other social agencies that contribute to the overall health pattern. This demands the organization of a hospital or health council for the community. These groups, following the pattern of the board, should represent a cross section of the community.

Our forebears in hospital work were isolationists, possibly through no fault of their own. They had no common purpose. Today we have a common purpose; we have something to work for.

We find written in the recommendations made by the Commission on Hospital Care an indication of how a disorganized hospital system can be transformed into an entirely comprehensible plan for providing the best possible care for all of the people at the lowest possible cost.

Now is our opportunity to interpret to every man, woman and child that purpose in their own terms so that they will know what it promises for them. That is the concept of true trusteeship: to serve as interpreter and guide on matters of health and hospital care to his community, to work for others and with others.

The Economics of Anesthesiology Service

W. ALLEN CONROY, M.D.
Director of Anesthesiology
St. Luke's Hospital, Chicago

CRITICISM of hospital management of anesthesiology service is growing rapidly. Dissatisfaction is partly based on the too obvious fact that the anesthesiology department, like the radiology department, is expected to show a profit to help make up deficits elsewhere in the hospital.

This is a serious matter of medical ethics since anesthesiology is a recognized medical specialty and not merely a technical service to be bought and sold at a profit. Apart from the profit angle, there might be the question of the legality and propriety of hospitals' dispensing this medical care through the medium of salaried physicians and anesthesia nurses.

"Profitable" and "Nonprofitable" Hospital Services. Even if it could be argued that any hospital has a right or responsibility to provide anesthesiology services, the common practice of making this medical service show a profit is condemned by organized medicine, with the explicit concurrence of hospital organizations. The following quotation is from a resolution of the board of trustees of the American Medical Association, which has been accepted without reservation by the American Hospital Association:

"A qualified medical specialist in anesthesia is entitled to recognition as a professional member of the medical staff and as head of a hospital department. . . . Neither the hospital nor the anesthetist should exploit the patient or each other."

If the hospital collects in anesthetic fees more than is spent to provide anesthesiology services, the patients are being exploited. The patient who has the misfortune to require surgical care and anesthesia is being made to carry an extra burden for another patient who requires only domiciliary care or who is benefiting from some service that is not carrying its proper financial burden. The niggardly salaries paid to many anesthesiologists and the reluctance to employ enough of them in many hospitals represent exploitation of the physician anesthetist.

Anesthesiology Is Part of Medical Practice. The fiction that the administration of anesthetics is even remotely comparable to the administration of other drugs dies hard. The needs of most operations require that anesthesia be carried much closer to a fatal dosage of the drug than is true in any other branch of therapeutics. Sudden alterations in the patient's condition may occur from the effects of either anesthetic or operation, and only a physician thoroughly trained in the physiology and pharmacology of the anesthesia process can correctly manage the minute details of resuscitative measures.

Under the best of conditions, accidents happen and, contrary to the usual impression, these are oftener due to lack of knowledge on the part of the anesthetic administrator than to any irremediable deficiency in the patient.

We cannot dodge the issue of the propriety and wisdom of having nurses conduct anesthesia by saying that they do so under the guidance of the surgeon or other physician. This is another fallacy, to be tolerated only as long as properly trained physician anesthetists are still scarce. It is a legal loophole, to be rectified by an honest approach as soon as feasible.

Few surgeons are technically and scientifically prepared to supervise anesthetic administration; how, then, can it be argued that they could do so, even if they were free to? Their whole attention is and should be concentrated on the accomplishment of the operative procedure. Nor can one or two anesthesiologists properly supervise the work of large numbers of anesthesia nurses. They may be able to improve the service immensely, but until all patients receive the same quality of care, it cannot be claimed that the ideal has been reached.

In actual practice, a nurse with only rudimentary knowledge of vital physiology and pharmacology, and a few months of technical training, is forced into the unhappy situation of being the principal arbiter of choice of drug and method. She is actually the one who must make emergency decisions which only a physician would be expected to make in any other field.

Doctors would be horrified at the suggestion that a nurse be allowed the same latitude in such a procedure as digitalization of a cardiac patient, where the subject's reactions must be properly interpreted every step of the way. Yet a fatal consequence is more likely from an error in anesthetic administration than it is from an error in digitalis dosage.

Nurses are being allowed to administer spinal anesthetics and to perform tracheal intubation in some hospitals. What a furore would be raised if it were suggested that nurses should be technically trained to do

The views expressed by the author are not necessarily those of the medical board of St. Luke's Hospital.

encephalography or that they be allowed to pass cystoscopes!

We cannot forget that the public wants the best services obtainable, and for that it has always been willing to pay. Modern advances in anesthesiology have forced upon physician specialists the need of a minimum of from two to four years of intensive training after medical school and internship. New and necessary anesthesia procedures have outdistanced the anesthesia nurse, whose total medical training consists of less than half that of the nonspecialist physician and only about one third that of the anesthesiologist.

Moreover, the care of patients during operations is only one of many services that the anesthesia department can give. Preoperative medication, fluid therapy, oxygen therapy and the treatment of postanesthesia complications are only a few of the accessory services the anesthesiologist is prepared to provide. These cannot be expected of anesthesia nurses.

Hospital-Anesthesiologist Relationship. Present arrangements for anesthesiology service in hospitals are varied. At one extreme is the salaried anesthesia department, with the hospital collecting all the fees. At the other extreme is the independent consultant anesthesiologist, who is responsible only to the organized hospital medical staff. A brief summary of the present day types of hospital-anesthesiologist relationships is pertinent.

Straight Salary System

1. In its weakest form, the anesthesiology department consists only of anesthesia nurses, theoretically responsible to a physician who seldom exercises actual control in the department. At the present time nothing better may be obtainable, but this is no excuse for failure to attempt an improvement, nor is it justification for making a profit for the hospital from the anesthesia service.

2. Next is the department that is headed by a physician who has anesthesiology training but that allows nurses to perform the greater part of the work. Even when a competent assistant anesthesiologist is also provided, the physicians may become only dispensers of specialized technics beyond the capabilities of the nurses and "trouble-shooters" for the nurses. They actually have much to offer to all cases were it possible for them to care for all.

Different fees may be justifiable for patients receiving the physicians' services, but at the same time the physicians should be paid what they are actually worth. To pay them less than their net earnings would put the hospital in the position of practicing medicine, with a profit derived from exploitation of the physician.

3. In this group the department is comprised of all physicians who are paid a straight salary. With a group of physicians, the straight salary plan can be justified only when all other physicians are employed by the hospital, as is the case in some medical school hospitals and in charity and state institutions.

It is incorrect to insist that the voluntary hospital has any right or duty to provide such anesthesia service when it does not provide the services of obstetricians or pediatricians or surgeons. Nor can it be argued that because service must be provided to "all comers," as in radiology, anesthesia must be a hospital service. (Recent court decisions in some states have made it illegal for a hospital to prohibit a duly recognized radiologist from carrying on a private practice within its confines.) Anesthesiology essentially concerns a direct relationship between patients and anesthesiologist, uninfluenced by the attitude of any third party except the surgeon.

Salary-Plus-Fees Plans

1. A few hospitals, notably some connected with medical schools, pay the anesthesiologists a retainer to provide for supervision of anesthesia nurses and interns, or for teaching duties, but allow the physician to collect all or part of the fees for private patients to whom any direct services are rendered. This is an ethical arrangement, though not ideal if the nurse-doctor ratio is high.

2. A variation of this plan is acceptable when an all-physician department cannot be immediately achieved. The physician collects his own fees from patients he himself anesthetizes and receives a percentage of the fees collected by the hospital for the nurses' cases, in return for supervision of the nurses' work.

Fee Plans

1. Group Practice. To provide the type of continuous coverage for all patients that can be obtained with the plans outlined, and still maintain the proper doctor-patient relationship, some anesthesiologists have entered into group practice of the specialty. Even where the group could not possibly provide for all cases, the plan is workable and quite as efficient as any salary scheme.

Special variants of the plan have been developed for special situations. If nurses must be used to provide enough personnel, they can be hired by the group or by the hospital. In the latter instance, the hospital would collect fees for the nurses' cases and pay a percentage to the group for supervision of the nurses' work. The cost of equipment and supplies would be borne by the hospital in the same manner as for operating room material, and the cost would be recovered similarly, divorced entirely from the professional services rendered.

In the hospital that has more than enough anesthesiologists on the medical staff to cover all the work, the services could be provided on an independent fee basis. This situation exists in many British and Canadian hospitals but, at best, American hospitals can obtain only barely enough physicians, who must arrange their time in the most efficient manner possible if all cases are to be provided for on an equitable basis.

If the anesthesiologists are on a partnership basis, they can divide up the work in a way that causes a minimum of wasted time and provides a maximum of service, without interfering with patient and surgeon relationships. This also avoids jeopardizing the income of the ones who might be anesthetizing free cases. The same virtues exist when it comes to loss of time from illness or attendance at medical meetings. My views on this subject have been more fully treated in another publication.*

2. Independent Fee Practice. This method is rarely of any direct moment to the hospital and at present cannot be considered an efficient enough alternative to any other plan to commend itself either to the surgical staff or to the hospital. In spite of its inefficient use of the anesthesiologist's time, it will have its place in communities where there are enough physician anesthetists to

*The Salary System: Handcuffs for the Anesthesiologist. Medical Economics 23:11 (August) 1946.

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allow for some lost time and in small hospitals where one or two doctors who have general practices are also interested in conducting anesthesia.

Commentary. The hospital is not entirely to blame for the development of the present unethical and unscientific arrangements in the anesthesia department. The specialty was neglected by the medical profession in the past, while at the same time surgeons kept demanding complete and continuous anesthesia service. With no one else to provide for this need, the hospital administrator was pushed into the position where he felt that there was a responsibility for the institution to meet the demand. However, the hospital that fails to recognize the status of anesthesiology today or the one that looks upon anesthesia service as its "property" for budget-balancing purposes may be open to criticism and even to legal action.

Modern surgery is making new demands on anesthesiology that cannot safely and efficiently be met by the anesthesia nurse. The hospital that clings to its control of the anesthesiology department through the hiring of many nurses and a few anesthesiologists is doing medical science a real disservice. Surgeons are gradually coming to recognize this.

Already some hospitals have found it difficult to obtain or to hold anesthesiologists on a salary basis, in spite of the great increase in the number of these specialists in the last ten years. The result is that surgical procedures that are safely performed with the help of good anesthesia are becoming unsafe or even impossible in places in which the financial status of the anesthesiologist is governed by the hospital budget and in which such restrictions have limited the number and quality of anesthesiologists.

Admittedly, there are many problems to be overcome in any change-over from present practices. Profit from the anesthesiology service represents a vested interest on the part of the hospital, and only concerted action by the doctors concerned may force the hand of some. This difficulty need not be looked upon as unsurmountable if all departments of the hospital are made to carry their proportionate burden of costs.

Certain clinical departments may offer objections to any sort of private fee plan. For example, it is the practice in some places to offer "flat rates" for some types of hospital care; inasmuch as anesthesia was in the past considered to be a hospital service, the flat rate would include this service, too. Here, some financial concession would have to be made by the hospital if doctors and patients concerned desired the continued service of anesthesiologists.

On the other hand, the present arrangement might be continued for flat rate cases if those involved were willing to accept only such service as might be provided by hospital anesthesia nurses or interns. There will even be objection from a few surgeons who fear that a fee system will cause extra burdens for their patients. When better service results, no patient in his right mind should object. Actually, the scale of fees now being charged by many hospitals would provide adequate compensation to anesthesiologists once the hospital profit is eliminated.

Progressive hospitals will evaluate today's developments in the economics of anesthesiology and take the necessary action to protect their good reputations. What seems like retreat in the economic field will eventually be seen to be insurance against future deterioration and an immediate gain in better service to all patients.

NOTES AND ABSTRACTS

Prepared by the Committee on Pharmacy and Therapeutics, University of Illinois College of Medicine, Chicago 12

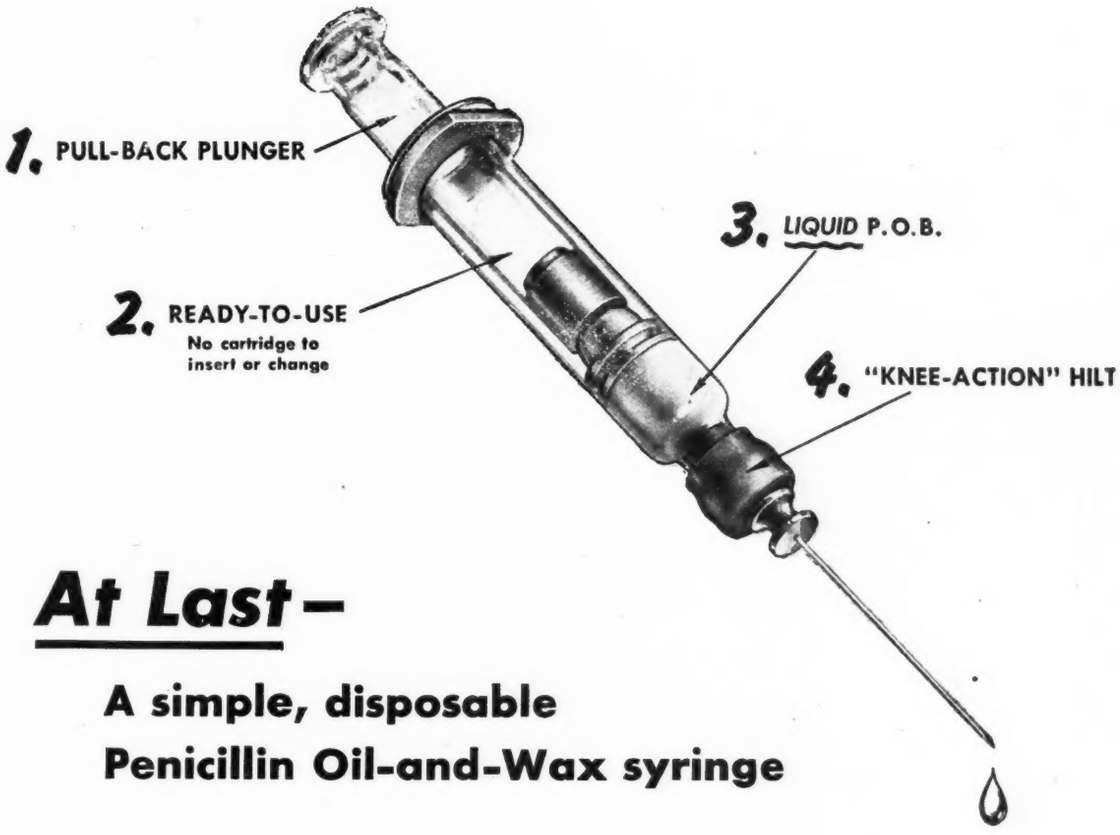
Reactions to Penicillin Therapy

PENICILLIN has come to be looked upon as a relatively nontoxic substance. This is because the percentage of patients receiving the drug and exhibiting reactions is very small and because the therapeutic index is extremely high. It is probably one of the most efficacious substances used in therapeutics, and in turn its absolute toxicity by normal routes of administration is practically zero.

As a matter of fact, Welch and his co-workers of the Food and Drug Administration state that the toxicity of pure penicillin is due to the cation present since penicillin salts and homologous acetates have similar toxicities in mice. However, if the potency of the preparation is low, the toxic effects are probably due to the penicillin. In contrast, millions of units administered to patients do not effect any deleterious action in the vast majority of cases. The sodium, potassium or calcium ion so administered is without observable toxic effect in the human being since the amount administered is such a small fraction of that already present that ionic equilibrium is not disturbed and, hence, no toxic reactions, as are effected in smaller animals, are seen.

Anaphylactoid Phenomena. While absolute toxicity in the human being can readily be dismissed, untoward reactions do occur, particularly in those patients with an allergy diathesis. But even in these cases the incidence is not high. Lyons, while at Halloran General Hospital, found that less than 6 per cent of army personnel treated for surgical infections exhibited allergic phenomena. Urticaria seems to be the commoner reaction, some of these cases developing angioneurotic edema also. A condition similar to serum sickness with swollen, painful joints, fever, albuminuria, insomnia and exhaustion has been reported by several authors. Contact dermatitis and eczematoid dermatitis also have been reported as due to penicillin.

A number of other conditions, such as changes in menstruation, abortion, miscarriage and cheilitis, have been associated with penicillin



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therapy but the reports are so individualistic as to suggest that factors other than the drug may be involved. There is no doubt that a relatively small number of patients do show some reaction of hypersensitivity to penicillin.

It is of interest to note that immediate reactions, generalized rash, edema and "id" reactions are reported by Kolodny and Denhoff (from Harmon General Hospital) as occurring in a high percentage of their patients with existing skin disease as compared to those having other illnesses. In 17 out of 18 cases exacerbation of a persisting skin disorder was induced.

While some of the reactions may be due to impurities, Welch and Rostenberg of the F.D.A. have reported a hypersensitivity to crystalline penicillin. Chow and McKree, working at Squibb Institute, have shown that crystalline penicillin combines with human plasma albumen. Such combination is probably antigenic and would account for the penicillin precipitins demonstrated by Criep of Pittsburgh.

While the immediate reactions to penicillin are disturbing to the patients, they are usually of short duration and subside on withdrawal of the drug. In some reports even the continuance of the penicillin was accompanied by a subsiding of the reactions in four or five days.

Much more alarming are the delayed reactions which occur one to two weeks following therapy. A syndrome similar to serum sickness has been reported by several writers. The symptoms may be intense although severity is a variable factor. Such reactions can usually be controlled by antihistamine drug therapy (benadryl, pyribenzamine) but will subside normally in four or five days on discontinuance.

Reactions at Site of Injection. The formation of sterile abscesses in syphilitic persons has been reported by several authors. These may develop either at the site of injection or where an injection of some other substance has been made. Whether this specific reaction is due to the primary irritation of the penicillin or to an antigen-antibody reaction is problematical.

In addition, several reports have been made of thrombophlebitis occurring after intravenous infusion of penicillin. Darmady, among others, reports aseptic necrosis at site of continuous intramuscular penicillin infusion. These reactions would seem to indicate a specific irritant action of the drug. In England, Howells and Kerr, and Turner have reported the occurrence of toxic hepatitis following penicillin therapy. This effect may be due either to the liver acting as the shock organ or to a specific toxic action.

Effects on Central Nervous System. Abraham et al. (1941), also in England, in a fairly complete paper noted that intracisternal application of penicillin in rabbits anesthetized with pentobarbital did not effect any disturbing reactions. The penicillin used was of low titre and comparatively impure. No doubt, the barbiturate would have prevented any signs of meningeal irritation or stimulation of brain tissue had the dose of penicillin been larger. The brains of these two animals were normal at postmortem examination.

Russell and Beck continuing this work (from Oxford) found that penicillin applied to the cortex or in-

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jected into the cortex produced a marked tissue reponse. Edema, ischemic degeneration and hemorrhage occurred, and in one animal a massive necrosis extending to the wall of the lateral ventricle was found. These authors state that concentrated penicillin cannot be recommended for local application to brain tissue.

In 1945 there appeared the first of a series of articles by Johnson and Walker of Billings Hospital concerning the effects of penicillin on the central nervous system. Their attention was drawn to the irritant effect of the drug by the development of convulsive manifestations in a child following the intraventricular administration of fairly large amounts (50,000 units) of commercial penicillin. They made a rather exhaustive study of the neuropharmacodynamics of penicillin and other antibiotics, both in animals and in human beings. They were able to demonstrate in monkeys an irritant effect when the drug (20,000 units) was given into the lumbar subarachnoid space.

While the symptoms were of a mild sensory type they were similar to those reported in the human being by Sweet et al., who also report two cases of sacral radiculitis occurring during therapy for pneumococcic meningitis. Sweet of Gallinger Municipal Hospital also states that in two cases showing cerebral atrophy and mental deterioration the drug may have been a causative factor since it had been given into the lateral ventricles.

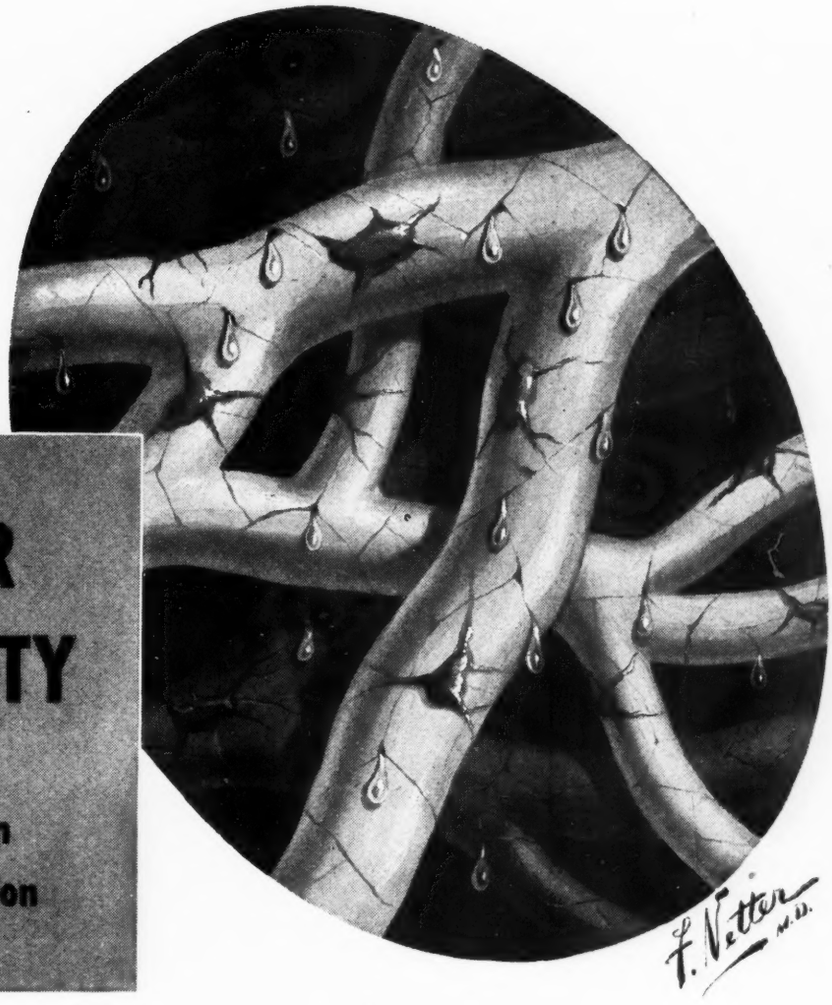
While they advocate the intrathecal administration of penicillin they warn that the dosage should be kept low, from 10,000 to 20,000 units a day; the dose should be well diluted, and the administration should be shifted to conventional routes as soon as the patient shows a favorable response. They felt the reactions they encountered were due to the irritant effect of the penicillin or of impurities present.

Neymans, Hulbrunn and Youmans (Chicago State Hospital), in treating five cases of dementia paralytica, found that penicillin could not be forced through the hematoencephalic barrier, either by massive intravenous doses or by bile salts or by artificial fever, nor did any appear in the spinal fluid after intramuscular injection. One of their patients who received 100,000 units intracisternally developed twitching and convulsions. Recovery took place under oxygen and sodium amytal therapy.

Two of the five patients died ten days after the last intracisternal injection. They warn that the intracisternal injection of more than 30,000 units is dangerous and that daily administration of this dose for more than five days is hazardous.

While Cutting et al. of Stanford University concluded that small intracisternal doses did not effect any serious meningeal irritation in dogs, and Rammelkamp and Keifer of Boston noted only nausea, vomiting or headache to follow intracisternal penicillin (10,000 units) in patients, Johnson et al. found that convulsions occurred in the dog, cat, monkey and man when the drug is applied directly to the central nervous system.

Of 51 patients receiving penicillin for some condition other than a neurological one they found 31 to show abnormalities in the electroencephalographic tracings. In some there was evidence of increased elec-



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trical activity; one case showed abortive or subclinical epileptic seizures; seven had a similar pattern after withdrawal of the drug, the record suggesting a convulsive diathesis. That their results are not due to impurities is proved by their use of pure crystalline penicillin.

In our own laboratory we found the intracisternal injection of small doses of pure crystalline G or X penicillin into rabbits to be followed in a few minutes by twitching of the nose, which proceeded quickly to periodic epileptiform convulsions. Penicillin X seems to be more convulsant than G. The animals may recover spontaneously in several hours but with larger doses (5000 to 10,000 units), death occurs. The convulsions are readily controlled by the intravenous injection of pentobarbital sodium or phenobarbital sodium. Gross examination of the brain shows marked hyperemia and some hemorrhage.

Johnson et al. report that other antibiotics, streptomycin, streptothricin, actinomycin and clavacin have a similar effect. Penicillin and streptomycin are the only two with sufficient margin of safety to be given into the cerebrospinal fluid.

Summary. 1. Reactions to penicillin therapy may be divided into anaphylactoid, local tissue damage and specific convulsant effects on the central nervous system.

2. Anaphylactoid reactions usually respond to antihistamine drug therapy and the local tissue damage has been decreased by the use of purer preparations of penicillin.

3. C.N.S. toxicity may be prevented by limiting the dosage of intrathecal penicillin to 30,000 units and by substituting parathecal routes of administration as soon as the patient responds to therapy.

4. The convulsive syndrome resulting from local application of penicillin to the central nervous system is easily controlled by the use of the soluble barbiturates.—W. J. R. Camp, M.D.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Curare Here to Stay

In "Experience With Curare in Anesthesia" by Dr. Virginia Apgar in the *Annals of Surgery* for August 1946, the author quotes statistically her experience with 200 operative cases in demonstrating that curare, as an adjunct in anesthesia, is a safe, noncomplicating drug when used by an anesthetist experienced in signs of anesthesia and the technic of endotracheal intubation.

Curare, as reported, was used in conjunction with either ether, pentothal or cyclopropane, usually for operations on the upper or lower abdomen, the head and neck or the chest (intrapleural). The drug was used to relax the surgical field or to aid in endotracheal intubation.

Complications during the use of curare, relatively few in number, are cited. Respiratory depression was the commonest. Two deaths occurred during anesthesia in this series. One was due to hemorrhage; the other, considered to be due to an overdosage of curare, is described in detail. Postoperative complications applicable to anesthesia were mainly respiratory, were infrequent and were not clearly related to the use of curare. The author feels that, although a wealth of information remains to be gained about the drug, curare is here to stay.—Benjamin Cohen, M.D.

FOOD SERVICE

CONDUCTED BY MARY P. HUDDLESON

Ways to Simplify the Work

Technics and methods evolved by motion and time study engineers might well be adapted by the dietitian to her own "food factory"

ORPHA MAE THOMAS
Assistant Professor of Institution Management
Teachers College, Columbia University

LET us consider a few of the newer methods of determining kitchen equipment requirements, making use of the technics developed by the motion and time study engineers. The terms they use may be new but I shall translate them into the terminology used in the institutional kitchen.

There are several ways of collecting valuable information in our existing kitchens. One method is to make process or flow charts of each of our typical products. Even though each day's menu is different the items in our food factory, for that is what a kitchen really is, can be grouped into classes according to the cooking processes involved.

For example, meats are roasted, broiled, panbroiled, fried, deep fat fried, stewed or braised. Vegetables are boiled, steamed, mashed, broiled or baked. By following typical products it is possible to find the history of each operation, the amount of space required for processing, the pieces of equipment needed and the time required for each process.

Data on Equipment Usage

Another method of collecting data is making machine operation charts, as the industrial engineers would call them. We might call this information data on equipment usage. This can be accomplished by watching each piece of equipment for a stated period, for example, a week, during which time all the various types of food to be prepared are included. If the starting and stopping time, the name of the employe using the equipment, the product processed and the quantity of that product are recorded the result will be a case history of the usefulness of each piece of equipment studied.

Man operation charts or records of the activities of representative workers will give information on the movements of workers, why they go to certain places, what they get there and what they leave or bring back.

What is the reason for all this observation and recording? From it we are beginning to develop tables of capacities of various pieces of equipment. Another type of information useful in planning and rearranging equipment is the sequence of routings which a product follows. If we know this, we can shorten the routes used oftenest. Standard time for various jobs is another type of information that industry is collecting. We can also collect timings on repetitive operations and be better able to make effective work schedules for our employes.

The advantages of such information are obvious. In our planning we shall include the pieces of equipment actually needed and the sizes required for the amounts of production necessary in our own operation. We shall exclude pieces of equipment not actually needed. We can arrange the equipment for more effective use of labor by departments and can place some of it in areas that are accessible to several departments.

With all this we can achieve greater production with less help and less expense. Our workers will be less fatigued. And, a point that we must reckon with in these days, all this will not be resisted by organized labor. Workers will not resent having the proper equipment or having the equipment arranged conveniently.

Another Phase of Motion Economy

Job training is another phase of motion economy. During the war some of the government agencies set down definite steps by which to analyze jobs. Let us review these steps and then look at some of the principles of motion economy and work simplification methods.

Step 1 is to break down the job to be done. In doing this, list all details of the job exactly as it is now being done. Be sure details include all the items of labor, foods, tools and equipment. Get a clear picture in your mind of just how the work is done.

Step 2 is to question every detail of the job as it is done. Why is it necessary to do this job? What is its purpose? Where should it be done? When should it be done? If it is to be done, what is "the best way" to do it? In answering these, consider the question of the hand and body

From a paper presented at a meeting of the Greater New York Dietetic Association.

motions involved, the suitability of the equipment, the arrangements of the work place, the location of the materials or food ingredients to be used and the safety and comfort of the employes.

Step 3 is to develop the new method. This step can be taken with the cooperation of others. Some industries put up suggestion boxes, sometimes paying for ideas on ways of accomplishing more work. Let us look first at the question of why this job is necessary. Perhaps the complete job could be eliminated or details of the job could be eliminated.

Rearrangement of the equipment will eliminate some steps. At Teachers College, Columbia University, we have been transporting our dishes to the basement for washing and then elevating them to the service room. By bringing the dishwashing room to the main floor, we believe that we can eliminate at least three employes, thereby saving about $100 a week.

Combine All Details

Whenever it is practical, all details of the job to be done should be combined. If onions are to be chopped and cooked, for example, the peeling process is simplified if they are placed in hot water for five minutes before peeling. There will be less weeping over the job. When it comes to the actual peeling, it is easier to cut the bottom off the onions and then cut the onions in quarters before peeling them. The outer layers almost fall off after the bottoms are removed.

Husking corn on the cob is another good example. Most people husk the corn, pulling down a few of the husks at a time and then breaking them loose at the bottom or else breaking off the entire husk along the stem at the bottom of the husk. Let us consider doing it another way. Cut the bottoms of the ears with a heavy knife, making the cut against a hard surface and cutting it at about the last row of grains on the cob. Now the husks are loose at the bottom and their removal is a much simpler job. You might call this rearranging the work in a better sequence or rearranging the order of the steps to be done. It also involves simplifying the necessary details.

The industrial engineers have made detailed studies of all the motions involved in doing work and have developed a number of principles to assist in making the job simpler. Let us look at some of these principles and their applications to our kitchen work.

Transport empty is the motion of some means of transportation without a load. It may be a hand, the two hands, the entire worker or some mechanical means of carrying. The hand reaches for a knife, the two arms reach for a mixer bowl, the cook goes for a stock pot or an empty truck is taken to the refrigerator.

How can we effect economies in this process? Can the distance be reduced? Are there barriers that could be removed to make such transport empty follow a better path? Since workers see better within a 60° angle of vision, could the reach be confined within that area? Can it be arranged to have the material come to the worker instead of having him go for it? Or perhaps could an employe who receives a lower wage bring it? Transports on a horizontal plane are more easily accomplished than are those on a vertical plane. Can these transports be horizontal? Can this transport empty to get one object be combined with one which entails getting rid of some other object?

Grasp is the motion of getting an object under control. This control may be accomplished in a variety of ways. The grasping tools may be fingers, tongs, arms, body or machines. Is the tool used for grasping the proper shape to grasp the object, as tongs for a muffin? Can one gather the proper amount with one grasp or with one load? Is the ladle or scoop the correct size for the size of the portion? Does the tool truly get the object under control, or can it slide off or loosen? Does the location in the serving pan help to facilitate this grasp?

Transport loaded is the carrying of an object or load from one place to another. The pencil is carried to the paper. The ladle of soup is carried to the bowl. The tray of dishes is taken from the clean dish table to storage. Let us apply motion economy here. Can the distance be reduced? Can trucks, trays or conveyors be used? Can this be made a multiple handling, taking several or a great number at one time? Is all the movement in one direction, always toward the point of service? Or is there backtracking? Can the material be moved on one plane? In the simpler jobs at one location, can the materials and equipment be arranged to eliminate passing material from one hand to the other? Would a tool assist in the transport, such as gloves in handling hot dishes? Both transports cost money. You are paying the employe to go empty handed as well as to return with a load. I am reminded of the drayman who rendered a bill:

5 Comes
5 Goes
50c a went $5

Release is the opposite of grasp and means relinquishing control. Of course, this varies from dropping a small object like a pencil to dumping something like a load of coal. To economize on motion, can several items be released at one time? Could the objects be dropped rather than set aside carefully? Could the pieces be tossed like potatoes into a bucket rather than placed-released, an exceedingly controlled movement?

Curved Movements Easiest

Is the release at a spot which requires no lifting as would be the case if the top of a bucket were placed below the working level when removing "eyes" from potatoes? Can the materials be dumped in one movement rather than ladled in many? Curved movements are accomplished much more readily than are abrupt changes of direction. Can trucks turn corners without stopping? Many building flaws slow down movement, and these are the fault of management.

Hold, another motion, is retaining an object while work is being performed on that object. The hand, especially the left hand, is often used for just that. This is time consuming and dangerous. The holding hand often gets hurt because the worker is conscious only of the working hand. Can dangerous holds be eliminated?

Do workers peel against a board? Can guides and stops be used to hold materials in place? Edges on shelves and trucks prevent trays from sliding off. A marine edge (a raised or rolled edge) on cooks' tables and sinks prevents spilled liquids from running onto the floor.

Preposition is locating the article in the approximate position for the next operation. Are all tools prepositioned near where they are used? Are pans placed by the pot washer conveniently for the cooks? Food parts could be prepositioned: for example, toast made in a broiler could be toasted in the counter pans ready to be covered with broccoli and cheese sauce.

Do lower salaried operators do all the prepositioning of materials possible? Are a large number of plates positioned on trays while the hands are clean, before the desserts are set up?

Positioning is placing an object in an exact and predetermined location. This often requires considerable adjustment as in gauging the thickness of a cut of meat. Because it is so exact, it is a time consuming motion. Could guides be used for eliminating controlled motions? Some of our guides in the kitchens are funnels, side and back stops on soiled and clean dish tables and special peelers for carrots and other vegetables with the peeling thickness determined by the set of the blade.

Make Selection Easier

Searching or locating objects with some uncertainty is always time consuming. The search may involve the eyes, the hands or all members of the body. *Finding* is the desired end of searching. *Selecting* is making a mental choice if several objects are found. The separation of these three movements is difficult but the combined movement involves only selection if tools and materials are conveniently located and are returned to proper positions. Different colored trays, labels or cans can be used to assist in selecting. Good lighting will assist. Indexing and arranging stocks will reduce searching time.

Assemble is the motion or several motions employed in combining several objects or parts of machinery to aid in more useful movements that follow. A mixer or slicer is assembled to use later. A food cutter or chopper is put together. The simpler this assembly, the more foolproof it can be made for the operator and the quicker it can be accomplished.

Disassemble is the opposite motion, taking machinery apart to release objects or to facilitate cleaning. We should know whether the tool is in scale with the job to be accomplished or whether we are "swatting flies with heavy machinery." Sometimes the assembly, disassembly and clean-up of a tool make it a "modern inconvenience."

Use, according to the industrial engineers, is the only element that determines productive output. The actual mixing, slicing, cooking and serving are our "use" motions. These cause a direct commodity change which enhances the value of the product. Industry has noted that less than 5 per cent of the total time spent in manufacturing a product is "use time."

Inspection, another fundamental motion, is the act of examining to see whether the object meets characteristic standards set up for it. It may employ any of the senses, as sight, smell or touch. In foods we test to determine whether they are done, later we examine for taste, appearance and temperature before the food is to be served.

When accepting food orders, we examine, weigh and count. Can inspection be reduced by weighing instead of counting if the number of portions does not depend upon units involved? Eggs can be weighed in the crate to reveal whether the count is all present and whether they are of the size ordered.

Delays are of several types. *Balance delay* is a wait for the movement of one portion of the body for another or for one machine to catch up with another. In some cases movements could be balanced by more symmetrical arrangements of the work area. Is each hand doing its share of the work, especially if hand motions are simultaneous?

Another type of delay is *avoidable delay.* Such a delay is not necessary in the process. It is illustrated by the dropped knife, the failure to order ingredients for planned foods, the deliberate waste of time in stalling and daydreaming or the using of improper tools, equipment and temperatures. Is the operator trained properly for this job? Does the supervisor establish and maintain with employes relationships conducive for working? Are hazards to safety eliminated?

Unavoidable delays are delays outside the control of the operator. The gas is turned off, a fuse burns out, a tumbler breaks in the hand, the mixer is broken. It is within our power as supervisors to reduce these delays. Are sufficient supplies on hand? Are proper tools provided and are repairs and maintenance kept up? Are the operators using the proper tools? Is the working space crowded? Is the employe working overtime when he is tired? Is the division of work among several operators according to time allotted and abilities?

Planning is a mental activity to decide the course of action. It may be consulting a recipe or work sheet. Most planning should be done by supervisors so that cooks and bakers will have little to decide, or it may be done at definite times in consultation and not require questioning regarding one point at a time.

Planned rest is designed to overcome fatigue. The amount of rest required will be reduced if other motions have been well planned. Reducing noise, providing sufficient ventilation, insisting on proper clothing, *i.e.* shoes, and selecting properly trained employes will reduce fatigue.

Put New Method to Use

There is one more step in the job analysis. That is to apply the new method. It will clarify the ideas on "savings" made if you write up your proposal or have your appointed supervisor do this. It will help to sell the new method to others. Explain the advantages of the new method and arrangement and how they will operate. Obtain any necessary approval so that everyone concerned will have been consulted. Check on the safety, quality and cost of each step. Get the new method into use.

Waiting kills ideas. Use the new method until a still better one is developed, but continue to look for a better way. We are expecting that some motion engineer will look at the six pallbearers at his funeral and say, "Put this thing on wheels and lay off five men." Recognize the assistance others have given you; giving credit stimulates more ideas.

Let me warn you about one item. Approach these changes with the idea of making the work easier for the employes. Never mention speed-up or reduction of labor costs. Remember it is *economy of motion and not the speed with which the elements are performed* that is the purpose of a time and motion study.

A dietitian checks a tray in St. Luke's new electric floor kitchen.

"Main 11" Looks Forward to Mealtime

GRACE ZERBOLIO
Chief Dietitian
St. Luke's Hospital
Chicago

THE patients on our "Main 11" ward floor at St. Luke's Hospital, Chicago, looked on with the greatest of interest during the installation of the new, all electric floor kitchen.

Food is important to patients as a physically important therapeutic factor in their care and is perhaps even more significant from a morale building standpoint. It plays as important a part in the recovery of the patient as do his medicine, laboratory work and physical therapy. The remodeling of floor pantries was a part of our program to do everything possible for the welfare of the patient.

We found that efficient food service was impossible with the outmoded equipment and the physical setup that existed. As an example, for years such items as toast and coffee were transported from our main kitchen to the floor pantry where they remained until they could be served to patients. The result: lukewarm coffee, slightly stale, and toast which had lost its appetizing crispness and freshness. Hot food was often cold and cold food was warm before it reached the bedside. Our patients complained, but little could be done to alter the situation.

However, with the advent of the new equipment, a coffee urn was installed and fresh coffee is now a simple matter to prepare and serve hot at any time. An electric toaster was added, and now fresh, crisp toast reaches the patients, warm and tempting.

Where previously food was transported to the floor and placed in an outdated steam table too small to accommodate the necessary supplies, a new electric food cart, thermostatically controlled, now makes it possible for meals to reach each bedside piping hot.

The interior of the pantry was made more sanitary and pleasanter in appearance by the installation of white tile walls and stainless steel cupboards. Dish warmers ensure the retention of heat until the food reaches the patient; tray racks facilitate the assembling of food on easy-to-reach trays; electric hot plates replace the old gas burners for the heating of such foods as require it, and an electric refrigerator replaces the old brine system icebox of former days.

All food for patients still is prepared in the main kitchen and is transported to the service kitchen, but the new equipment eliminates the cooling of foods which should be served hot and the warming of refrigerated items. Service has been speeded up, with the result that patients receive their meals completely on schedule, with a minimum of effort on the part of personnel. As a consequence, complaints from patients regarding the service and the food have been reduced in great measure on this floor.

When the meal is finished, trays are loaded on a cart and returned to the pantry where a dishwashing machine has replaced the hand dishwashing of former days. There are also a new stainless steel sink and a portable stainless steel work table. A towel dryer in the pantry facilitates the work of the pantry maid. When the last dish is removed from the dishwasher, trays are again assembled on the racks in preparation for the next meal.

The menu offered to patients on the ward floors remains the same inasmuch as there is no choice of food on these floors. But the patient now looks forward to receiving hot, nourishing, attractive meals. Mealtime has become a point in the day which he anticipates happily, with the eager appetite that the doctor wishes him to have. His whole attitude toward his hospitalization changes for the better if he is not disappointed in his meals.

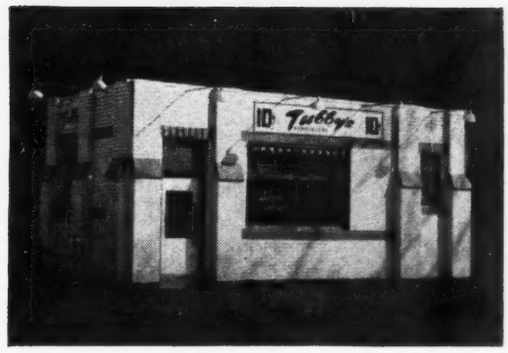
For the dietary department, this new equipment means that service of meals is accomplished with the minimum of effort. The time consumed in each step of the food service on the floor is reduced to the lowest possible point. The proper sanitary conditions are easily maintained within the shining walls of the reorganized and well equipped kitchen. There is a place for everything and everything is in its place.

Our aim has been accomplished, the aim of every dietary department, the service of food in a clean, attractive and palatable manner and at the proper temperature. Our all electric kitchen represents the realization of an ideal.

"No Wonder MAGIC ONIONS Are Winners!"

SAYS COLUMBUS, OHIO, SANDWICH SHOP OPERATOR

In the opinion of E. F. Kuhlwein, president of Tubby's, Inc., Columbus, Ohio, operator of a chain of sandwich shops, Magic Onions, the new food discovery, provide the answer to every onion problem. *"We use Magic Onions for all kinds of onion dishes,"* says Mr. Kuhlwein. *"Not only are they easy to serve but they save time and work, eliminate the job of peeling onions and their fresh, full flavor makes a hit with patrons. No wonder Magic Onions are having a remarkable success!"*



BECAUSE they banish onion problems for good and all, Magic Onions are constantly winning greater recognition, straight across the country! Hundreds of users, representing all types of eating places, not only report how easy Magic Onions are to serve but how pleased customers are with their superior flavor!

Restaurant operators endorse these five major advantages:

(1) Magic Onions save labor, eliminate odor and onion peeling.
(2) Give onion dishes the full flavor of the finest onions.
(3) Give year-round control of flavor, quality and costs.
(4) Save losses from spoilage and shrinkage.
(5) Reduce storage space requirements by 90%.

IDEAL FOR USE IN ALL ONION DISHES

Hamburgers, All Types of Sandwiches, Chili Con Carne, Chop Suey, Soups, Fried Onions, Creamed Onions, Liver and Onions, Salads, Stews, Steaks Smothered in Onions

ASK YOUR HEINZ MAN ABOUT

MAGIC ONIONS

Packed by Basic Vegetable Products Corp., Vacaville, California • DISTRIBUTED BY H. J. HEINZ CO., MAKERS OF FAMOUS 57 VARIETIES

Menus for April 1947

Margaret McDonald
Southside Hospital
Bayshore, Long Island, N. Y.

1
Tangerines
Soft-Cooked Eggs

•

Swiss Steak
Creamed Potatoes
Fresh String Beans
Chocolate Pudding

•

Chicken Salad
Potato Chips
Stuffed Olives
Bing Cherries
Advocate Creams

2
Stewed Prunes
Shirred Eggs

•

Cream of Tomato Soup
Halibut Steaks, Tartare Sauce
Mashed Potatoes
Harvard Beets
Fruit Gelatin, Custard Sauce

•

Spanish Omelet
Creamed Potatoes
Lettuce Hearts, Russian Dressing
Plums, Marshmallow Puffs

3
Oranges
Poached Eggs

•

Barley Broth
Roast Leg of Lamb, Spiced Pear
Parsleyed Potatoes
Frozen Peas
Ice Cream

•

Creamed Chipped Beef on Toast
Baked Idaho Potatoes
Asparagus Salad, French Dressing
Figs, Vanilla Wafers

4
Stewed Apricots
French Toast, Sirup

•

Clam Bisque
Broiled Bluefish With Lemon
Hashed Brown Potatoes
Parsleyed Carrots
Bread Pudding With Meringue

•

Baked Macaroni and Cheese
Grilled Tomatoes
Mixed Green Salad, French Dressing
Sliced Pineapple, Hermits

5
Applesauce
Soft-Cooked Eggs

•

Tomato Bouillon
Veal Birds
Creamed Potatoes
Fresh Spinach
Bavarian Cream With Whipped Cream

•

Broiled Lamb Chops
Buttered Broccoli
Tomato Aspic Salad
Peaches, Cookies

6
Half Grapefruit
Broiled Bacon

•

Broth With Noodles
Roast Turkey, Dressing
Cranberry Sauce
Glazed Sweet Potatoes
Creamed Cauliflower
Ice Cream

•

Cold Cuts
Escalloped Potatoes
Beet Salad
Fruit Cocktail, Cookies

7
Stewed Figs
Scrambled Eggs

•

Split Pea Soup
Baked Ham, Raisin Sauce
Creamed Potatoes
Acorn Squash
Baked Rice Custard

•

Stuffed Green Peppers
Glazed Sweet Potatoes
Perfection Salad
Royal Anne Cherries, Cake

8
Bananas
Shirred Eggs

•

Creole Soup
Roast Prime Ribs of Beef
Browned Potatoes
Creamed Celery
Butterscotch Pudding With Whipped Cream

•

Chow Mein
Rice
Crisp Noodles
Pineapple and Cream Cheese Salad
Gelatin, Cookies

9
Tomato Juice
Poached Eggs

•

Broth With Vermicelli
Broiled Lamb Chops
Parsleyed Potatoes
Brussels Sprouts
Deep Cherry Pie

•

Asparagus Tips With Cheese Sauce
Baked Potatoes
Avocado Ring Salad
Apricot Halves, Cake

10
Stewed Rhubarb
Broiled Bacon

•

Vegetable Soup
Broiled Liver and Bacon
Mashed Potatoes
Carrots and Peas
Ice Cream

•

Cold Boiled Ham
Potato Salad
Green Gage Plums
Chocolate Cookies

11
Orange Juice
Soft-Cooked Eggs

•

Clam Chowder
Baked Codfish, Tartare Sauce
French Fried Potatoes
Frozen Lima Beans
Apricot Upside-Down Cake
With Whipped Cream

•

Tuna Salad
Sliced Tomatoes
Potato Chips
Frozen Strawberries
Wafers

12
Stewed Prunes
French Toast, Sirup

•

Black Bean Soup
Smoked Beef Tongue With Gravy
Parsleyed Potatoes
Harvard Beets
Raisin-Rice Pudding

•

Baked Chicken and Noodles
Tomato and Lettuce Salad
Mixed Fresh Fruit Cake

13
Honey Dew Melon
Scrambled Eggs

•

Tomato Bouillon
Roast Chicken, Dressing
Cranberry Sauce
Mashed Potatoes
Fresh Brussels Sprouts
Ice Cream

•

Cold Cuts
Potato, Radish and Cucumber Salad
Bartlett Pears, Oatmeal Cookies

14
Grapefruit Juice
Soft-Cooked Eggs

•

Split Pea Soup With Croutons
Ham Steaks, Mustard Sauce
Parsleyed Potatoes
Creamed Spinach
Cottage Pudding, Chocolate Sauce

•

Meat Loaf, Mushroom Sauce
O'Brien Potatoes
Lettuce, Roquefort Cheese Dressing
Fruit Compote, Cake

15
Tangerines
Poached Eggs

•

Mulligatawny Soup
Pot Roast of Beef With Gravy
Mashed Potatoes
Yellow Squash
Strawberry Shortcake

•

One Quarter Broiler
Creole Rice
Macedoine of Vegetable Salad
Applesauce, Ginger Cookies

16
Stewed Apricots
Shirred Eggs

•

Cream of Asparagus Soup
Roast Leg of Veal, Dressing
Currant Jelly
Browned Potatoes
Parsleyed Carrots
Fruit Gelatin With Whipped Cream

•

Baked Chicken, Rice and Asparagus
Tomato Aspic Salad
Whole Apricots, Vanilla Wafers

17
Sliced Bananas
French Toast, Sirup

•

Cream of Pea Soup
Baked Ham, Raisin Sauce
Glazed Sweet Potatoes
Fresh String Beans
Ice Cream

•

Meat Patties, Brown Gravy
Stuffed Baked Potatoes
Shredded Lettuce, French Dressing
Royal Anne Cherries, Nabiscoes

18
Applesauce
Scrambled Eggs

•

Tomato Bisque
Fillet of Sole, Tartare Sauce
Parsleyed Potatoes
Grilled Tomato
Grapenut Custard

•

Codfish Cakes, Tomato Sauce
Broccoli
Endive and Chicory Salad
Halves of Peaches, Cake

19
Stewed Prunes
Soft-Cooked Eggs

•

Boiled Beef
Buttered Potatoes
Baby Beets and Carrots
Bavarian Cream

•

Meat and Vegetable Pie With Crust
Tomato and Lettuce Salad
Bing Cherries, Cookies

20
Half Grapefruit
Broiled Bacon

•

Broth With Vermicelli
Chicken Fricassee
Cranberry Sauce
Rice
Frozen Peas
Ice Cream

•

Cold Cuts
Baked Idaho Potatoes
Mixed Green Salad
Whole Apricots, Vanilla Wafers

21
Stewed Figs
Poached Eggs

•

Barley Broth
Roast Duck, Dressing
Applesauce
Mashed Potatoes
Succotash
Chocolate Cake With Boiled Icing

•

Stuffed Tomato and Egg Salad
Potato Chips
Mixed Fruit Cocktail
Raisin Cookies

22
Sliced Bananas
Shirred Eggs

•

Cream Soup
Broiled Steak
Mashed Potatoes
Fresh String Beans
Floating Island

•

Creamed Chicken on Toast
Baked Sweet Potatoes
Celery Stuffed With Creamed Cheese
Purple Plums, Cookies

23
Oranges
French Toast, Sirup

•

Celery Soup
Veal Cutlet, Tomato Sauce
Creamed Potatoes
Parsleyed Carrots
Baked Rice Custard

•

Mushroom Omelet
French Fried Potatoes
Lettuce Hearts
Green Gage Plums, Hermits

24
Tomato Juice
Scrambled Eggs

•

Chicken à la King
Rice
Frozen Lima Beans
Ice Cream

•

Corn Fritters With Sirup
Broiled Bacon
Tomato Aspic Salad
Sliced Pineapple Wafers

25
Grapefruit Sections
Soft-Cooked Eggs

•

Clam Chowder
Codfish Steaks, Tartare Sauce
Hashed Brown Potatoes
Fresh Spinach
Lemon Meringue Pudding

•

Salmon Loaf, Cream Sauce
Carrots
Waldorf and Pineapple Salad
Spiced Layer Cake

26
Stewed Rhubarb
Broiled Bacon

•

Creole Soup
Roast Leg of Lamb
Parsleyed Potatoes
Brussels Sprouts
Jelly Roll With Whipped Cream

•

Corned Beef Hash With Poached Egg
Endive With French Dressing
Bartlett Pears, Cookies

27
Honey Dew Melon
Coffee Ring and Jam

•

Bouillon With Rice
One Quarter Broiler
Mashed Potatoes
Fresh Asparagus, Butter Sauce
Ice Cream

•

Assorted Cold Cuts
Escalloped Potatoes
Pineapple and Cottage Cheese Salad
Hermits

28
Grapefruit Juice
Poached Eggs

•

Beef Tongue, Raisin Sauce
Parsleyed Potatoes
Creamed Celery and Peas
Deep Apple Pie

•

Potato Pancakes
Applesauce
Broiled Ham
Asparagus Salad
Bing Cherries, Wafers

29
Stewed Prunes
Soft-Cooked Eggs

•

Cream of Corn Soup
Broiled Lamb Chops
Mashed Potatoes
Frozen Peas
Tapioca Cream

•

Chicken Soufflé, Mushroom Gravy
Baked Stuffed Sweet Potatoes
Spring Salad
Apricots

30
Oranges
Scrambled Eggs

•

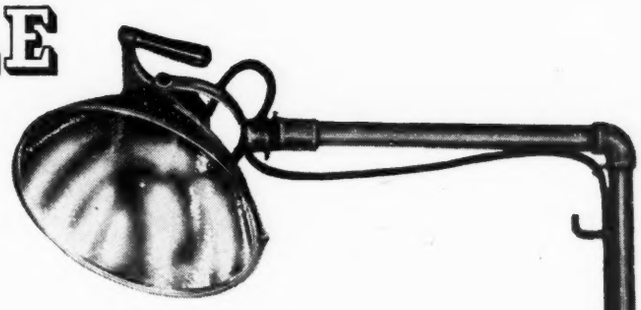
Tomato Bisque
Baked Ham Steaks, Mustard Sauce
Parsleyed Potatoes
Harvard Beets
Apple Scallop

•

Chopped Ham and Fresh Mushroom Patty
New Asparagus
Perfection Salad
Mixed Fruit Cocktail Cookies

Ready-to-eat or cooked cereals are offered on all breakfast menus.

SALE



Operating Lamp

Portable lamp, complete with spare parts and carrying case. Unit contains bulbs that can be used with dry cells, storage battery or 110-220-volt AC or DC current. Lamp stands 72″ high, has 12½″ lens.

Carrying case is a waterproof metal box 17½″ x 22½″ x 24″, weighs 105 pounds.

Send bids to one of these offices

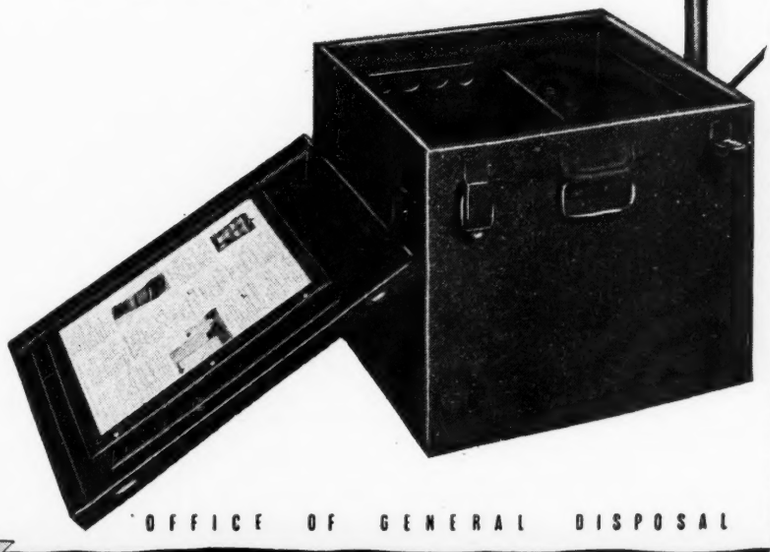
57 available in New York, N. Y.
37 Broadway

548 available in Atlanta, Ga.
699 Ponce de Leon Ave., N. E.

847 available in Denver, Colo.
728 Fifteenth Street

363 available in Richmond, Va.
East End Fourth Street

3500 available in Louisville, Ky.
412 West Market Street, P. O. Box 1259



HOW TO BUY

Bids will be accepted up to 5 P.M. on March 31, 1947. Bids may be made for any quantity.

Letters containing bids may be addressed to the War Assets Administration Regional Office holding inventory. Envelopes should be plainly marked in the lower left-hand corner "Sealed bid on Operating Lamps, Biplane Markers and Reorientating Devices. Opening date March 31, 1947."

Bids from veterans must show certification date, case number and location of certifying office.

Priority Purchasers are entitled to purchase surplus property at the fair value thereof. The fair value of this material will be determined by an analysis of bids submitted by non-priority bidders and will be the lowest price at which this material will be awarded to a non-priority bidder.

Bidders' letters should contain the following statement: "This offer is subject to War Assets Administration's standard conditions of sale, and all other advertised terms and conditions, and no other terms or conditions shall be binding on War Assets Administration."

EXPORTERS: Your bid is solicited. Any inquiries regarding export control should be referred to Office of International Trade, Department of Commerce, Washington, D. C.

OFFICE OF GENERAL DISPOSAL

WAR ASSETS ADMINISTRATION

GOVERNMENT WAA SURPLUS

Offices located at: Atlanta • Birmingham • Boston • Charlotte • Chicago • Cincinnati • Cleveland • Dallas Denver • Detroit • Fort Worth • Helena • Houston • Jacksonville • Kansas City, Mo. • Little Rock • Los Angeles • Louisville • Minneapolis • Nashville • New Orleans • New York • Omaha • Philadelphia • Portland, Ore. • Richmond • St. Louis • Salt Lake City • San Antonio • San Francisco • Seattle • Spokane • Tulsa

PLANT OPERATION & MAINTENANCE

Air Conditioning for Comfort and Safety

STARR PARKER
Mechanical Engineer
Cincinnati

THE use of comfort cooling in hospitals, greatly accelerated during the war, promises to be further extended within the next few years both for the comfort of the patients and the staff and for the diagnosis and special treatment of hospital cases.

Although only a limited number of small hospitals has been completely air conditioned, comfort cooling has been installed in many operating and recovery rooms, labor and delivery rooms, nurseries, x-ray treatment and developing rooms and special rooms for the treatment of patients suffering from heart diseases, high blood pressure, kidney disease, allergies, rheumatism and respiratory infections.

In a paper presented at the annual meeting of the American Society of Refrigeration Engineers and later published in *Refrigerating Engineering*[1] Dr. Albert G. Young, Corey Hill Hospital, Brookline, Mass., stated that the advantages of air conditioning the operating rooms are largely for the comfort of the staff.

Because anesthesia affects the human heat regulating center, located in the brain, it has been difficult to obtain exact data for the optimum temperature for operating rooms. The anesthetized human being at ordinary room temperatures suffers a fall in body temperature which is directly proportional to the depth of anesthesia and its duration. However, as the patient's body is covered during the operation, temperatures that provide comfortable working conditions for the staff are considered satisfactory for the patient.

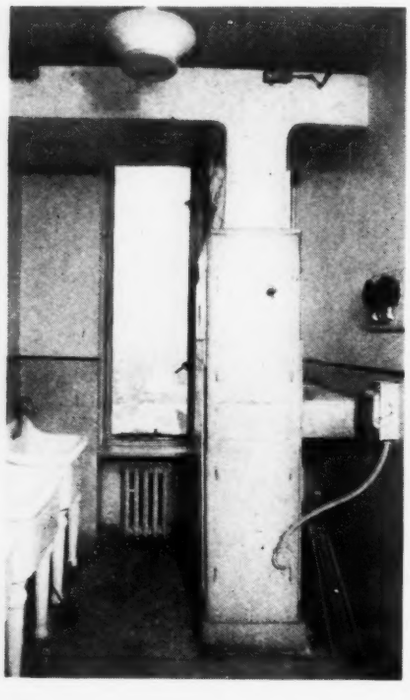
Design Conditions for Operating and Obstetrical Rooms. All of the air introduced into the operating or delivery room must be clean, filtered, fresh air because of the hazards involved in recirculating anesthetic and bacteria laden air. Ten or 15 air changes an hour are most commonly used.

Each installation should be made with either a cleanable or throwaway type of filter placed in the air intake duct. Electrostatic precipitators, entirely satisfactory for the purpose, have been limited to larger installations because of the cost.

Figure 1 shows the installation of a 5 h.p. air conditioner installed in the scrub room between two major surgery rooms at St. Luke's Hospital, Cleveland. Fresh air is taken into the back of the unit through a duct passing through the window to the outside. Filters are inserted into slots in this duct for easy replacement.

An "effective temperature" of from 68° to 69° F. was found by Houghton and Cook[2] to provide comfortable conditions for 80 per cent of the surgeons, interns and nurses. It was noted in this report that some will always feel too warm or too cool!

A relative humidity of between 50 and 60 per cent must be maintained in the operating room at all times to minimize the danger of explosion resulting from static spark[3]. With an average humidity of 55 per cent and an air velocity of 100 feet a minute the room dry bulb tempera-



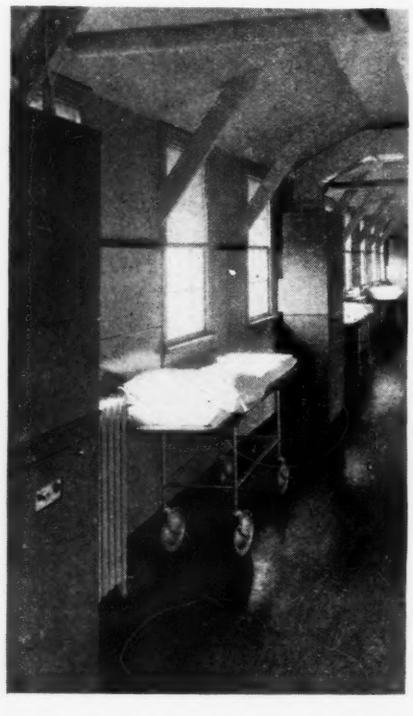


Fig. 1 (left): Unit air conditioner serving two operating rooms, St. Luke's Hospital, Cleveland. Fig. 2 (right): A typical air conditioning unit installation in an army cantonment hospital.

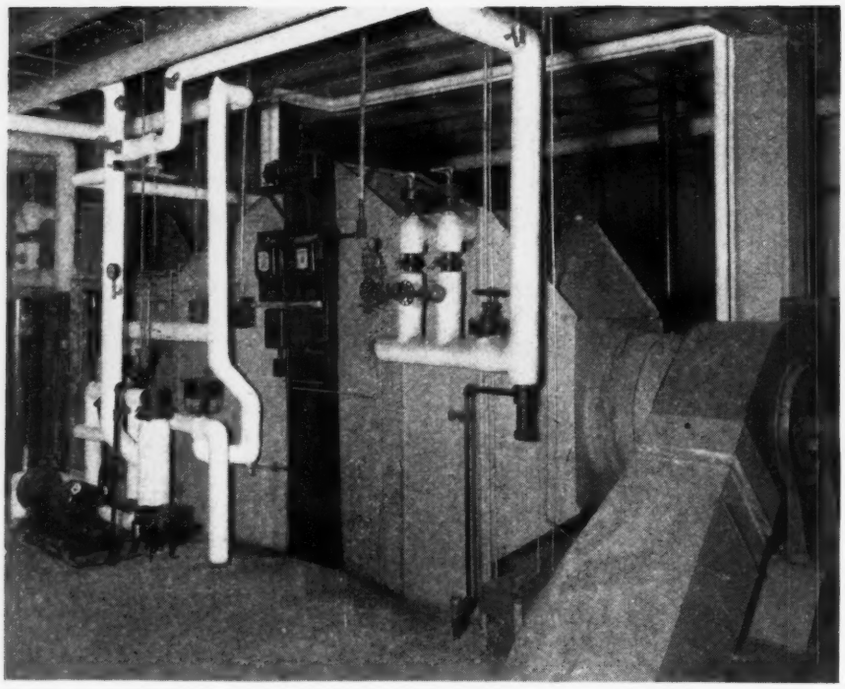


Fig. 3. Central station type of equipment, Women's Hospital, Detroit.

ture should be 75° F. or slightly above.

The characteristics of the refrigerating coils in most unit air conditioners are known to the manufacturers so that a selection can be made which will provide the proper conditions for summer use without the use of additional humidifying equipment.

A typical U. S. Army installation is shown in figure 2. Air is taken from the outside through the back of the unit and is distributed by means of the overhead ducts to the rooms served.

In all cases the units must be set outside the operating room to minimize explosion hazards and, because of the frequent use of anesthetics in labor rooms, these areas should be treated the same as operating and delivery rooms.

Recovery Rooms. Air conditioned recovery rooms are of greater benefit to the patient than are air conditioned operating rooms. As Dr. Young states[1]: "The average occurrence of postoperative pneumonia or similar complications in large hospitals[4] is between 6 and 7 per cent for all operations. In the first year of operation after air conditioning was installed in Corey Hill Hospital but one case of postoperative pneumonia occurred in the total of 743 cases for the year."

Furthermore, in 1916 Moschowitz[5] pointed out the danger of postoperative heat stroke and the fact that there is a great increase in postoperative deaths during a heat wave.

Various authorities recommend summer comfort conditions in recovery rooms of 80° F. and 35 per cent relative humidity with the equivalent of 20 per cent of the air circulated and introduced into the room as fresh air.

Cooling is accomplished by either individual room air conditioners or by air from a central system, such as that shown in figure 3.

Requirements for Nurseries. C. P. Yaglou[6] says: "One of the most important requirements in the care of premature infants is the stabilization of body temperature because their heat regulatory mechanism is not fully developed." Mortality rate was lowest[6] where the relative humidity was 65 per cent and air temperature requirements varied from 75° to 100° F. according to general constitution and body weight.

"The normal or full time infant,"

Fig. 4. Duct work is finished as part of the building.

Fig. 5. Air is distributed through grilles on far wall.

The inside facts on Varlar! How this miracle wall covering resists water, blood, grease, bacteria—stains of *all* kinds! How it begins a new day of low-cost wall beauty and maintenance in hospitals!

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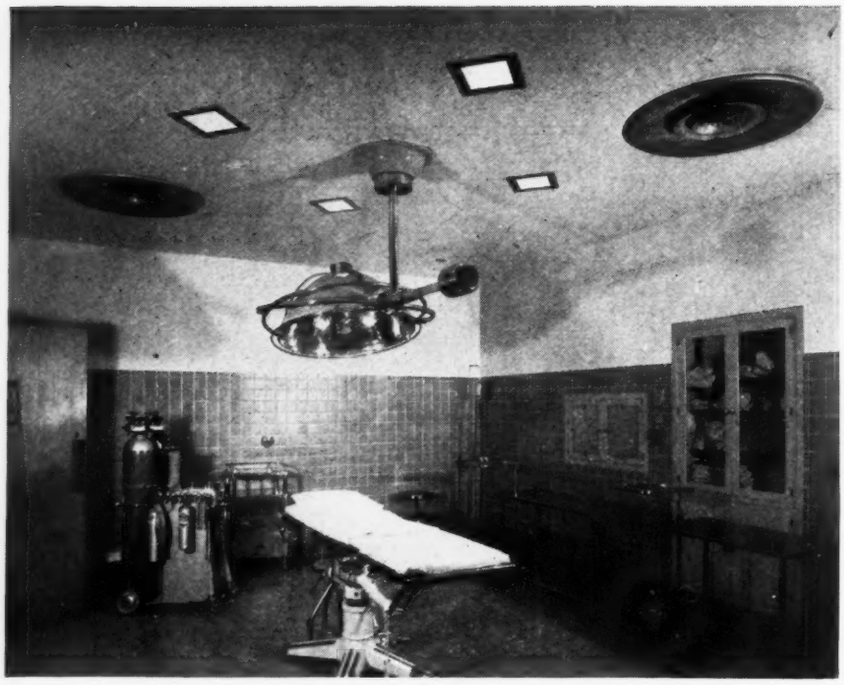

Fig. 6. Anemostat installed in the ceiling of an operating room.

says Doctor Young,[1] "benefits by an increased temperature and humidity for the first forty-eight hours after birth. After that he will thrive on the same conditions as outlined for the surgical recovery rooms."

Unit air conditioners have proved satisfactory in a number of installations.

Special Treatment and Work Rooms. The same factors that dictate acceptable comfort conditions for the occupants of any air conditioned space control the temperature and humidity in treatment rooms, x-ray developing rooms, fluoroscopic examination rooms and the like.

Here, a temperature of 75° F. or from 12° to 15° F. below the outside dry bulb temperature, whichever is the higher, is acceptable, with humidity maintained at from 20 to 35 per cent.

Special rooms for the treatment of respiratory infections should be held at 80° F. dry bulb and from 35 to 50 per cent humidity because cold dry air is irritating to the mucous membranes.

In the treatment of allergies, including hay fever and asthma, particular attention must be given to the exclusion of air leaks through doors, windows and other room openings. Fresh air filtration must be complete and the room must be rendered positively free of pollen, dust, powder and other air borne irritants.

Equipment Selection. The choice and location of equipment will in many instances be difficult because most hospitals were constructed before air conditioning was considered "indispensable."

When space is available and when several rooms are to be served at the same temperature and humidity conditions, a central station unit as pictured in figure 3 might prove most economical and satisfactory.

The principal objection to central station equipment is the extensive duct work which an installation of this type requires and the space requirements for this duct work.

In figure 4 the hallway and ceiling height are ample to permit the installation of duct work; the same is true of installations in which the ducts have not been finished, as in this case, to appear as part of the ceiling construction.

The refrigeration equipment required for an installation of this type may vary in cost from $5000 to $100,000. Individual unit coolers are usually best adapted to small isolated sections or to rooms in which the cost of installing equipment and ducts from a central station would be prohibitive. Such units as those shown in figures 1 and 2 will cost from $2000 to $3000.

So-called "room coolers" are usually used only in rooms where the cooling load is comparatively light, where the total comfort cooling requirements are low or where it is necessary to provide comfort cooling in a few smaller spaces.

Air Distribution Most Important. It is extremely important that all drafts be eliminated in all air conditioned rooms and this can be accomplished only by properly designed outlet grilles of which there are many types.

In the Grunow Clinic at Phoenix, Ariz., illustrated in figure 5, the decorative grilles on the far wall serve as the duct outlets. Other grilles are available with adjustable directional vanes that control air movement both horizontally and vertically. Furthermore, these grilles can also be equipped with sectional dampers to vary the volumes of air supplied.

Figure 6 illustrates an installation of one of the popular "anemostats" installed in a surgical room at Jewish Hospital, Cincinnati.

Accurate Design Essential. The control of air temperatures and air movement is an exact science and careful consideration must be given to each individual installation lest some single factor be neglected, with the result that the installation is unsatisfactory.

Results with any air conditioning system can be accurately predicted provided the system is accurately engineered and properly maintained.

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NEWS DIGEST

Offers Plan to Permit Hospitals to Collect Consultation Bills

A revolutionary plan which would permit the hospital to render bills and collect charges for medical consultation was proposed by Dr. F. W. Madison, chief of staff at Columbia Hospital, Milwaukee, in a talk to an American College of Hospital Administrators conference in Chicago February 17. Under the plan proposed by Dr. Madison, the charge made by a staff member called in consultation would appear on the hospital bill. The hospital would then collect the bill from the patient and pay the consultant.

"Good consultation service doesn't just happen, it has to be worked for," Dr. Madison declared.

Fifty A.C.H.A. members from 20 states attended the four day educational conference in Chicago February 17 to 21, hearing lectures and taking part in seminars on various types of administrative problems. Charles E. Prall, director of the A.C.H.A.-A.H.A. joint commission on education, was coordinator for the program, which presented 19 nationally known hospital leaders as faculty and consultants.

Public Concerned With Service

"The public assumes that hospitals have good doctors," Dr. Madison told the conference. "Its concern is with nursing service and food rather than medical care, which is taken for granted."

Dr. Madison described the medical council at his hospital and told how it operates, approaching problems of medical quality in an educational spirit instead of with the "policing" concept. He emphasized the importance of a well planned teaching program for interns and residents and of clinical investigative work as aids in the improvement of medical standards. Particularly, he said, the pathology and radiology services in the hospital have an important bearing on the quality of medical service rendered.

Dr. Robert A. Moore, professor of pathology and dean of the school of medicine at Washington University, St. Louis, recommended that all surgical tissues, including tonsils, should be examined by the pathologist. He emphasized the importance of postmortem examinations, not to determine the cause of death, but to offer educational opportunities for staff members.

Taft Bill Would Consolidate All Health Activities in One Agency

By EVA ADAMS CROSS

WASHINGTON, D. C.—Sen. Robert A. Taft introduced on February 11 a health bill "fundamentally different" from the Murray-Wagner-Dingell Bill endorsed last year by President Truman. Co-sponsors are Senators Joseph H. Ball, H. Alexander Smith and Forrest C. Donnell. The new national health bill is designed to assure substantial extension of hospital and medical service throughout the United States.

The proposed legislation would consolidate all of the health activities of the federal government in a new independent national health agency to be headed by an outstanding physician. The agency would have responsibility for federal governmental activities concerned with the administration of the Hospital Survey and Construction Act; the administration of funds appropriated as grants to states for medical and hospital care, dental care and hospital facilities; the promotion of maternal, prenatal and child care, and numerous other health activities.

The bill would provide $200,000,000 yearly for general medical, surgical and hospital service and for dental service, an annual increasing amount up to $20,000,000. Complete control is left with state and local governments. Financial contributions to be made by the states, and their governmental subdivisions, shall be at least equal to the amount contributed for similar purposes in 1946 and at least equal to the federal aid to be provided.

Other features of the bill are:

1. $10,000,000 for cancer control. This money is intended for the necessary function of attacking cancer at its inception through the medium of diagnostic clinics to be set up in the states. It is not intended for research or treatment.

2. Periodical medical examinations of all children in public and nonpublic, primary and secondary schools. Free treatment will be given only to those unable to pay for it.

3. Dental services to include dental examinations of all children in public and nonpublic elementary and secondary schools, and dental care for those unable to pay for such services.

4. $3,000,000 for a survey of health and medical care resources in the states; and $1,000,000 for a survey of dental care resources in the states.

5. The establishment of a national institute of dental research at a cost of $2,000,000.

Medical programs would be under the administrative jurisdiction of the health agencies within the states, instead of under welfare and social agencies. The states would be given until 1949 to accomplish this objective. Payments of premiums into voluntary health plans for welfare cases would be encouraged so that they will be treated the same as the cases of other insured persons.

Sum Can Be Deducted

Under the new proposal, any federal employe who wishes to join a voluntary health insurance fund may direct the government to deduct the necessary sum from his pay and apply it directly to the fund. Voluntary health insurance plans would be encouraged, said Senator Taft, so that health insurance may be available to the great numbers of those who desire it without forcing anyone, patient or doctor, to abandon his present practices.

As a condition of obtaining federal aid, each state would make a comprehensive survey of the health activities throughout the state, both public and private, urban and rural, with special reference to the medical care provided for the lower income groups. Based on this survey, the state must propose a plan by which hospital service and medical service in hospitals and clinics are made available to all families and individuals unable to pay for such services. The hospital bill promotes the construction of rural hospitals; this bill will add the medical service, Senator Taft declared.

Taft-Fulbright Hearings Started

WASHINGTON, D. C.—Initial hearings on the Taft-Fulbright Bill began in Washington February 28. The bill seeks to establish a national department of health education and security in the federal government at the cabinet level. If this bill should be enacted, Senator Taft explained at the hearing, the National Health Agency Bill which he introduced with Senators Ball, Smith and Donnell on February 11 will be amended to conform to the new department.

Alarming Deficit of Doctors Predicted at A.M.A. Meeting

The nation is facing an alarming deficit in the number of physicians practicing compared to medical care needs, Dr. Thomas Parran, surgeon general of the U. S. Public Health Service, told medical deans gathered in Chicago February 10 for the forty-third annual Congress on Medical Education and Licensure.

Especially with the hospital construction program contemplated under Public Law 725, Dr. Parran said, medical education programs need to be speeded up immediately if a serious shortage of physicians at the end of another ten years is to be avoided. Considering existing needs, anticipated population gains and scientific trends, Dr. Parran said, present educational facilities are inadequate to furnish the number of physicians that will be needed.

He recommended an exhaustive survey to determine needs for medical service along the lines of the present survey of hospital facilities. The survey should also disclose whether federal aid is needed on the basis of grants-in-aid to states. Dr. Parran commended the American Medical Association for the survey of medical education which is about to be undertaken under the auspices of its Council on Medical Education and Hospitals.

Discussing Dr. Parran's paper, Graham Davis of the W. K. Kellogg Foundation, president-elect of the American Hospital Association, commented that occasional opinions to the effect that Public Law 725 is "an entering wedge for state medicine" have been heard in the field. Mr. Davis reminded the deans that similar comments were made during the early days of the Blue Cross movement 10 years ago. He declared that the present hospital facilities program will not increase government domination of hospitals; on the contrary, he said, it cannot fail to strengthen the voluntary system.

Referring to Dr. Parran's estimate that as many as 30,000 additional physicians may be needed by 1960 if medical schools do not quickly enlarge their facilities, Dr. Arthur C. Bachmeyer, director of the University of Chicago clinics, added that the age of physicians now practicing in rural communities is an additional factor pointing toward the impending physician shortage. Since young medical graduates are reluctant to migrate from big cities into rural areas, he pointed out, some systematic effort should be commenced immediately to interest boys in small towns and rural areas in attending medical school. When such boys are graduated, he said, they would probably be willing to return to their home communities to practice.

Bureau of Standards Keeps Division of Simplified Practice

Culminating a protracted campaign by the American Hospital Association and other interested professional groups, the U. S. Department of Commerce announced last month that the Divisions of Simplified Practice and Trade Standards would be retained in the National Bureau of Standards. Previously, the divisions' functions had been ordered transferred to the Secretary of Commerce.

"The two divisions are essentially fact finding and coordinating agencies," the department's announcement said. "Acting as clearing houses for industrial, distributor and buyer groups, they develop standards only upon written request of interested parties. Promulgation of these standards is dependent upon written acceptance from the trade representing a satisfactory volume of business in the commodity covered. In accepting a standard, the producer, distributor or user says, in effect, that he considers it a useful standard of practice and plans to utilize it as far as practical in his business, reserving the right to depart from the standard so long as no deception results from such departure.

"In establishing a standard or recommendation, the divisions depend upon the information sources represented by the industry or trade association for which the work is being done."

Among the hospital groups which took part in the effort to have these divisions retained in the National Bureau of Standards were the American Hospital Association, the Cleveland Hospital Council, the Hospital Bureau of Standards and Supplies and The Modern Hospital Publishing Company.

Scientific Information Bill

WASHINGTON, D. C.—Senators J. W. Fulbright and George D. Aiken in February introduced a bill providing for the orderly administration of a program to make the discoveries of engineers, inventors, scientists and technicians more readily available to American industry and business, particularly to small enterprise. A similar measure was introduced in the last Congress by Senator Fulbright.

Hospital Survey Act Highlighted in Parran Report to Congress

WASHINGTON, D. C.—Passage of the Hospital Survey and Construction Act was highlighted in Surgeon General Thomas Parran's annual report of the Public Health Service to Congress February 13. He pointed out that in the launching of the five year program a national policy has been established whereby hospitals and health centers are to be planned, located and operated in relation to the overall health needs of the people.

Dr. Parran also stressed the passage of the National Mental Health Act as marking the first large scale, coordinated attack on a problem which affects some 8,000,000 Americans, and fills more than half of our hospital beds. The act provides for a National Institute of Mental Health and for federal aid in research, in training of badly needed personnel and in the development of state and local mental hygiene services and clinics.

Another notable development, said the surgeon general, was the adoption of a World Health Organization to operate under the United Nations. This constitution, already ratified by five nations, is dedicated to active promotion of world health.

Among public health activities covered by the report are laboratory and field research on a wide variety of diseases and health hazards; assistance to states and communities in strengthening their health organizations; special programs in cancer research and control, industrial hygiene, and control of tuberculosis and venereal diseases; medical services to the Coast Guard and other government agencies; operation of Marine Hospitals and medical relief stations for merchant seamen and other legal beneficiaries, and hospitals for drug addicts and mental patients.

The growing importance of heart disease, cancer and other chronic conditions of later life in our aging population was emphasized in the report.

Social Security Sought

WASHINGTON, D. C.—A bill was introduced in the Senate in February to amend the Social Security Act so that states and political subdivisions and instrumentalities thereof may obtain coverage for their officers and employes under the old age and survivors' insurance provisions. A more recent bill introduced in the House would give employes of religious, charitable, scientific, literary and educational institutions the benefits of coverage under the Social Security Act, the Federal Unemployment Tax Act and the Federal Insurance Contributions Act.

Charitable Services of Methodist Hospitals Total $2,600,000 in '46

With all its 70 hospitals operating on acceptable scientific and social lines, it is the aim of the Methodist Church to add the "plus" of healing Christianity to their services, Karl P. Meister, executive secretary of the Methodist Board of Hospitals and Homes declared in his report to the sixth annual meeting of the board in Chicago February 11. Methodist hospitals are in operation in 29 states and cared for nearly 1,000,000 patients during the last year, Mr. Meister reported. Charitable services rendered by these hospitals aggregated $2,600,000.

In an address on personnel efficiency, Warren F. Cook of New England Deaconess Hospital, Boston, outlined what hospital employes have a right to expect from the employer. He listed justice in human relations, respect for the dignity and integrity of the worker and job security as principal employe rights.

To implement these rights, Dr. Cook suggested an employes' committee consisting of elected representatives from every department to meet with hospital executives periodically for discussion of employe problems. Such meetings, he said, also provided an excellent opportunity for the administrator to explain the hospital's problems and objectives to employes with a view to obtaining their sympathetic understanding.

Speaking for Lee J. Mamer, who was unable to be present at the meeting, Dr. Roger W. DeBusk, director of Evanston Hospital, Evanston, Ill., and president of the Chicago Hospital Council, urged administrators to select either a graduate engineer or someone with equivalent training or experience to take charge of the hospital plant. He pointed out that the power plant is literally the heart of the hospital and can be costly in operation if it is not properly supervised.

Detailing the many features of plant operation which may result in waste unless careful controls and records are kept, Dr. DeBusk also mentioned the importance of maintaining all tools and equipment in first class shape as insurance against heavy repair and replacement costs. He suggested that the hospital engineer be called in consultation with the administrator and architect on all building and expansion programs.

Dr. Frank R. Bradley of Barnes Hospital, St. Louis, discussed the underlying philosophy of hospital administration in modern society and outlined the essential features of administrative training. Others who addressed the hospital section of the meeting were Robert E. Neff, superintendent of Methodist Hospital, Indianapolis, and Everett W. Jones.

Amended Order M-43 Permits More Use of Tin

WASHINGTON, D. C.—The tin conservation order, M-43, has been amended to permit more use of the metal.

Important relaxations in the amendments are: permission to use tinplate of specified weights for domestic kitchen equipment; pure tin pipe is now regarded as pig tin and may be used for the manufacture of food and beverage dispensing units; tin oxide may now be used in the production of earthenware plumbing fixtures; tin may now be used to plate snap fasteners, hooks and eyes, and the percentage of tin allowed for use in solder is increased.

Other significant changes in the order are: Tin content for dental foil is now unlimited as compared with a former 30 per cent restriction. Tin or tin chemicals may be used as laboratory reagents, for medicinal purposes and for plating processes where such plating is permitted by the order. Tin oxide may now be used for the production of chrome green, pink, yellow and red.

Cancer Council Approves $300,000 Grants-in-Aid

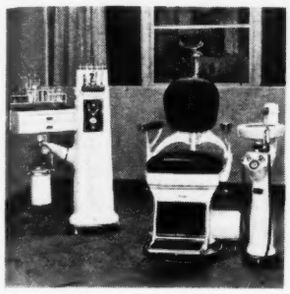
WASHINGTON, D. C.—The thirty-third session of the National Advisory Cancer Council was held at the National Cancer Institute February 17 and 18. The council considered applications for federal grants to support cancer research at institutions throughout the country. Future needs of cancer research and the need for expansion of the research fellowship program came up for discussion.

Two new members recently appointed to serve on the council are: Dr. Waltman Walters, surgeon, Mayo Clinic, and Dr. Shields Warren, assistant professor of pathology, Harvard Medical School. The council is composed of outstanding authorities in the study, diagnosis or treatment of cancer.

In its two day meeting the council approved grants-in-aid aggregating $300,000 for 25 research projects to be conducted in 18 universities, hospitals and other private institutions.

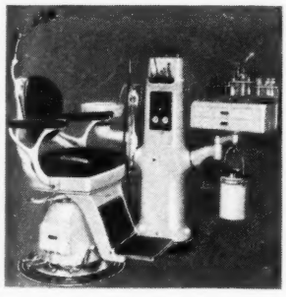
Would Continue Cadet Corps

WASHINGTON, D. C.—On February 19 Representative Lane introduced a bill to continue in effect, until June 30, 1950, the provisions of the act of June 15, 1943, Public Law 74, 78th Congress. This is the law which established the Cadet Nurse Corps relating to the training of nurses through grants to institutions for such training. The bill has been referred to the Committee on Interstate and Foreign Commerce.

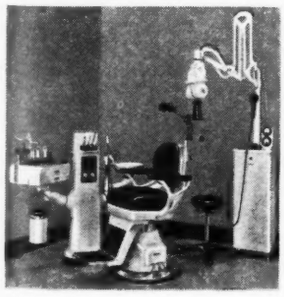


This Ritter Unit is positioned at left, with Surgical Cuspidor at right of chair.

This Ritter Unit is for the physician who prefers to work with instruments and medicaments at right, Ritter Surgical Cuspidor at left of chair.



This type of Ritter Unit, with Swinging Cuspidor, is positioned at right of chair.



Here the Ritter Unit, also with Swinging Cuspidor, is placed at left of chair.

Your Specialists Can Serve More Patients... Easily...with the correct RITTER ENT UNIT for their special needs

With modern, energy-saving equipment your specialists can extend their skill to more patients without added strain.

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Shown here are the four types of Ritter Units. Now is the time to choose the Units which can best help your specialists serve more patients. *Ritter Company, Inc., Ritter Park, Rochester 3, N. Y.*

FOR ADVANCED EQUIPMENT LOOK TO **Ritter**

Legion Advisers Hold Three Day Conference

WASHINGTON, D. C.—A three day conference of American Legion medical advisers was held at the District Medical Society Auditorium February 20 to 22. The three surgeons general of the United States—Maj. Gen. Norman T. Kirk of the army, R. Adm. Clifford A. Swanson of the navy, and Dr. Thomas A. Parran, U.S.P.H.S., addressed the gathering.

Dr. Charles Mayo of the Mayo Clinic led a panel discussion on hospitalization and outpatient treatment. Dr. Howard A. Rusk conducted a demonstration of rehabilitation technics. Other speakers included Dr. Paul R. Hawley, medical director of the Veterans Administration; Brig. Gen. Wallace H. Graham, physician to President Truman, and Watson B. Miller, Federal Security Administrator.

Dr. Parran in an address delivered by Deputy Surgeon General James A. Crabtree warned that little or nothing has been done to relieve the critical shortage of doctors, scientists, dentists, nurses and engineers urgently needed in both preventive and curative fields of medicine.

COMING MEETINGS

ALABAMA HOSPITAL ASSOCIATION, Jefferson Davis Hotel, Montgomery, March 14-15.

AMERICAN COLLEGE OF SURGEONS, Sectional Meetings: Omaha, March 14-15; Fort Worth, March 20-21; Providence, R. I., March 28-29; San Francisco, April 7-8; Vancouver, B. C., April 21-22; Winnipeg, Man., April 28-29.

AMERICAN DIETETIC ASSOCIATION, Philadelphia, Oct. 13-15.

AMERICAN HOSPITAL ASSOCIATION, Hotel Jefferson, St. Louis, Sept. 22-25.

ARKANSAS HOSPITAL ASSOCIATION, Little Rock, May 15-16.

ASSOCIATION OF WESTERN HOSPITALS, Seattle, Wash., May 12-15.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Roanoke, Va., April 2-4.

CATHOLIC HOSPITAL ASSOCIATION, Mechanics Hall, Boston, June 16-20.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Buffalo, May 21-23.

IOWA HOSPITAL ASSOCIATION, Des Moines, April 21-23.

KENTUCKY HOSPITAL ASSOCIATION, Phoenix Hotel, Lexington, March 27-28.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 23-25.

NEW ENGLAND HOSPITAL ASSEMBLY, Hotel Statler, Boston, March 24-26.

NEW JERSEY HOSPITAL ASSOCIATION, Dennis Hotel, Atlantic City, May 15-17.

OHIO HOSPITAL ASSOCIATION, Deshler-Wallick Hotel, Columbus, April 8-10.

PENNSYLVANIA HOSPITAL ASSOCIATION, Pittsburgh, April 23-25.

SOUTHEASTERN HOSPITAL CONFERENCE, Hotel Buena Vista, Biloxi, Miss., April 10-12.

TEXAS HOSPITAL ASSOCIATION, Rice Hotel, Houston, March 27-29.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 5-7.

WASHINGTON STATE HOSPITAL ASSOCIATION, Seattle, May 11-15.

Wisconsin Needs 7000 Hospital Beds Survey Reveals

The state of Wisconsin needs 4000 general and 3000 convalescent hospital beds, Vincent Otis, hospital survey director for the state board of health, reported to the midwinter conference of the Wisconsin Hospital Association in Milwaukee February 20. Wisconsin needs 15,000 beds in general hospitals, Mr. Otis said the survey revealed, but only 10,735 are available. Beds for chronic and convalescent patients total only 2800 out of a needed 6300, he said.

Esther Klingman of Neenah was named president-elect of the association as Joseph G. Norby of Milwaukee took over the presidency.

A plea for general hospitals to accept patients with poliomyelitis was made by Dr. Kenneth S. Landauer of the National Foundation for Infantile Paralysis, who commended the association for its effort in this direction, resulting in acceptance of polio patients by more than 20 hospitals in the state. Hospitals refusing polio and other communicable diseases are failing to accept their community responsibilities, Dr. Landauer declared.

Left to right: Joseph G. Norby of Columbia Hospital, Milwaukee; Dr. Carl N. Nupert, state health officer, Madison, and Dr. V. Wilson, chief, section of special services, Minnesota Department of Health, study the official publication of the Wisconsin Hospital Association.

Dr. V. Wilson of the Minnesota State Health Department addressed the meeting on the subject of hospital licensure. The fundamental of a good hospital licensing law, he said, is its inclusion of adequate minimum standards for construction, equipment and management. A good law, Dr. Wilson pointed out, prevents the opening of substandard hospitals and causes existing institutions to raise their standards. For new hospital projects, Dr. Wilson recommended the closest possible cooperation among hospital administrators, trustees and architects. He also urged careful surveys to determine the need for hospital facilities in any area before construction plans are made.

Hospitals in a community should work closely together to analyze costs and adjust rates accordingly, Guy Clark of the Cleveland Hospital Council told the association. Rates charged to individual patients, Blue Cross, insurance companies and government agencies must be adequate to cover full costs, Mr. Clark said, including depreciation on plant and equipment. He also recommended inclusion of a 5 per cent contingency fund to assure adequate working capital at all times.

Homer Wickenden explained the operation of the National Health and Welfare Association's retirement plan for hospital employes; Dr. F. W. Madison of Milwaukee talked on controlling the quality of medical care in the hospital, and George Bugbee, executive director of the American Hospital Association, stressed the rôle of the hospital as the focal point for all the health activities in the community.

In addition to Miss Klingman, officers elected by the association were: first vice president, Omer Maphis, Kenosha; second vice president, Sister M. Pulcheria, Milwaukee; treasurer, Merton Knisely, Milwaukee; trustees, Franklin Carr, Sturgeon Bay, and Rev. E. J. Goebel, director of Catholic hospitals in Wisconsin. N. E. Hanshus of Eau Claire is secretary of the association.

D. C. Hospital Plan Raises Payments to Member Hospitals

WASHINGTON, D. C.—A new schedule of payments to District of Columbia hospitals was announced by Group Hospitalization, Inc., February 19. The hospitals will receive an increase of approximately 22.6 per cent above the present contract. The new schedule, long under consideration, is the result of a series of conferences between committees representing G.H.I. and the Metropolitan Area Hospital Council.

It is estimated that the boost in payments to the hospitals will cost G.H.I. $250,000 a year. The rate increase is hailed as one which will go far toward solving financial difficulties of Washington's voluntary, nonprofit hospitals. It is expected that the new contract will call for an increase in the monthly dues of subscribers, although the president of G.H.I. says that a change in subscription charges will be deferred until a more permanent formula for reimbursing member hospitals is determined.

Group Health Association, Inc., recently announced a 50 cent increase in membership dues to meet higher operating costs for the nonprofit medical service cooperative.

G. I. Bill Not Affected by End of Hostilities

WASHINGTON, D. C.—President Truman's recent proclamation ending hostilities has no effect on the laws administered by the Veterans Administration, according to an official decision of this agency. Foremost among these laws is the G.I. Bill. The official termination of the war, not the cessation of hostilities, is the determining factor in establishing the deadline for the educational and readjustment allowance provisions of the G.I. Bill. The same thing holds true of Public Law 16 covering vocational rehabilitation for disabled veterans.

The four year limitation for education or job training under the G.I. Bill and the nine year limitation under Public Law 16 will not begin until the President or Congress declares the official termination of the war.

Penn R.R. Gives $150,000

F. G. Grimshaw, campaign chairman of the recent fund raising program for the Altoona Hospital, Altoona, Pa., has announced that the Pennsylvania Railroad has contributed $150,000 to the hospital's building fund program. This brings the total subscribed in the campaign to $1,230,000, against the original announced objective of $750,000.

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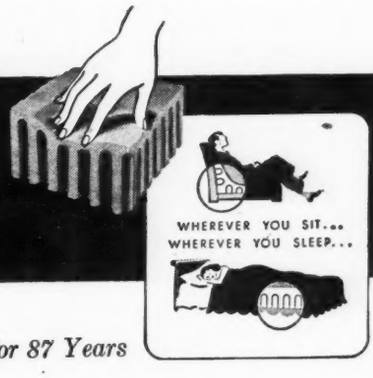

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New England, Texas .. Associations Announce Convention Programs

Heading the list of hospital conventions scheduled for March are the New England Hospital Assembly, to be held in Boston, March 24-26, and the Texas Hospital Association meeting in Houston, March 27-29.

Other March meetings include the Alabama Hospital Association in Montgomery, March 14-15, and the Kentucky Association in Lexington, March 27-28.

A special feature of the New England meeting will be a one day institute for hospital trustees. Planned by Dr. Gerald F. Houser of Boston, chairman, and Raymond P. Sloan, editor of The Modern Hospital, coordinator, the institute program has the theme, "Planning the Hospital of Tomorrow." Among the speakers are Dr. Vane Hoge, chief of the Hospital Facilities Division, U. S. Public Health Service; Dr. Basil MacLean of Rochester, N. Y., who will speak from the point of view of the hospital consultant; Robert W. Cutler of New York, architect; Cornelius Smith of New York, fund raising counsel; Dr. E. M. Bluestone of New York, who will discuss the trustee's obligation to maintain medical standards, and several hospital trustees from the New England area.

According to Paul J. Spencer of the Lowell General Hospital, Lowell, Mass., who is secretary of the assembly, the attendance is expected to surpass last year's record crowd of 2500. Mr. Spencer and the program committee have developed a series of provocative questions as themes for the various section meetings. Among these are, "Do you know what you've bought and where it is?" for the discussion of purchasing and stores; "Would you like to work for you?" for the personnel section; "What's your curbstone reputation?" for community relations; "How's your luck at collecting autographs?" for medical records, and many others for the assembly's 20 separate sections.

The Texas meeting will be held jointly with the state associations of nurse anesthetists, medical record librarians, occupational therapists and women's auxiliaries. On the first evening of the convention, March 27, a public assembly will be held in the Houston Music Hall, at which Everett W. Jones, vice president of The Modern Hospital Publishing Company, will speak on "The Future of the Voluntary Hospital." Tol Terrell of Harris Memorial Methodist Hospital, Fort Worth, president of the Texas association, will make his annual report at this meeting.

Also addressing the Texas group at various sessions during the convention will be John H. Hayes of New York, president of the American Hospital Association; Dean Conley, executive secretary of the American College of Hospital Administrators, and Norman B. Roberts, director of the Texas hospital survey.

Dr. MacEachern Honored

A plaque honoring Dr. Malcolm T. MacEachern, associate director of the

American College of Surgeons, was unveiled at the annual meeting of the staff of St. Mary's Hospital, Duluth, Minn., last month. The memorial plaque honors Dr. MacEachern's contribution to American hospital standards.

Hospital Fund-Raising

A Record that speaks for itself

21 Recent Successful Hospital Campaigns

Directed by Ward, Wells & Dreshman

Hospital	*Objective*	*Amount Raised*	*Completed*
Reading Hospital, Reading, Pa.	$2,000,000	$2,270,000	6/ 7/46
St. Clare's Hospital, Schenectady, N. Y.	1,200,000	1,500,000	8/31/45
Mercy Hospital, Springfield, Ohio	1,000,000	1,004,479	8/20/46
St. Joseph's Infirmary, Atlanta, Ga.	1,000,000	1,000,000	6/ 5/46
Brockton Hospital, Brockton, Mass.	650,000	960,000	1/15/47
Easton Hospital, Easton, Pa.	750,000	828,455	6/26/46
Allentown Hospital, Allentown, Pa.	550,000	689,000	12/20/44
Collins Colored Hospital, Memphis, Tenn.	300,000	500,000	9/30/45
Rockingham Memorial Hospital, Harrisonburg, Va.	300,000	428,000	1/15/47
Riverhead Hospital, Riverhead, L. I., N. Y.	400,000	426,600†	2/25/46
Pottsville Hospital, Pottsville, Pa.	350,000	411,500	1/23/46
Newton Memorial Hospital, Newton, N. J.	400,000	400,690	10/12/46
St. Mary's Hospital, Amsterdam, N. Y.	450,000	400,000	5/27/46
Waltham Hospital, Waltham, Mass.	350,000	400,000	1/21/46
Braddock General Hospital, Braddock, Pa.	300,000	275,000	2/46
Benedictine Hospital, Kingston, N. Y.	250,000	275,000	10/18/45
Perth Amboy General Hospital, Perth Amboy, N. J.	250,000	240,000	1/11/46
Good Samaritan Hospital, Pottsville, Pa.	100,000	122,634	2/26/45
Beaver Valley General Hospital, New Brighton, Pa.	110,000	122,420	1/24/45
Sacred Heart Hospital, Norristown, Pa.	100,000	120,000	2/19/45
Silver Cross Hospital, Joliet, Ill.	50,000	75,000	7/31/44

† *Second Campaign this summer yielded an additional $150,000.*

FOUR OF THE ABOVE campaigns were for the purpose of establishing NEW Hospitals.
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California Hospitals Adopt Program to Beat Health Insurance Bills

By ALDEN B. MILLS

The Association of California Hospitals has adopted a three point program in an effort to make unnecessary the sweeping compulsory health insurance which has been proposed by Gov. Earl Warren. The governor's program has the support of the C.I.O. and, somewhat lukewarmly, of the A.F. of L. It is opposed by other powerful groups, such as the American Legion and the railroad unions.

The three point program of the hospitals is aimed at obtaining (1) adequate facilities in all parts of the state to meet the needs of the public as will be revealed by the state's hospital survey; (2) adequate educational facilities and recruitment of enough students to provide sufficient personnel to meet present and future needs of the state without relying so heavily on migration from other areas; (3) adequate voluntary prepayment plans for both medical and hospital costs so that the people of the state may have access to the care they need without undue hardship.

The California hospitals at their convention in Santa Barbara on February 12 and 13 appropriated $4250 to get this program started and are inviting the doctors, dentists, nurses, pharmacists and other professional groups concerned and the various agencies that will pay for the program—capital, labor and agriculture—to join hands in making it effective. It is hoped to obtain a budget of $50,000 or more per year in cash and various aids in service to carry on the educational program.

Hospital Licensing Effective

The experiences of the state health department in its first year of licensing hospitals in California were told to the convention by Dr. J. B. Askew, chief of the bureau of hospital inspection. From his review it was apparent to the members that hospital licensing had been necessary and was becoming effective.

The cost of hospital construction has probably reached its peak and should now show some decline, according to a paper prepared by Douglas Dacre Stone, San Francisco architect, and read in his absence by a member of his firm.

The largest amount of general discussion from the floor occurred over the paper by A. C. Jensen of Fairmont Hospital, San Leandro, recommending the training of attendants to carry on from 50 to 65 per cent of the duties now carried on by graduate nurses in those hospitals which do not have practical nurses or ward aides. When the administrators

reached home they found a similar recommendation from the American College of Surgeons on their desks.

New officers of the association were elected to take office on May 1. They are: President, Dr. J. A. Katzive, Mount Zion Hospital, San Francisco; president-elect, LeRoy Bruce, administrator, Los Angeles County Hospital; first vice president, Margaret Wherry, Good Samaritan Hospital, Los Angeles; second vice president, V. W. Olney, St. Luke's Hospital, San Francisco; treasurer, Charles Wordell, Children's Hospital, San Francisco; trustees, George U. Wood, Peralta Hospital, Oakland; Alden B. Mills, Huntington Memorial Hospital, Pasadena, and Dr. Otis Whitecotton, Alameda County Hospitals, Oakland. The retiring president, Arthur J. Will, Superintendent of Charities, Los Angeles County, is also automatically elected as a trustee.

Per Capita Allotment of Sugar Increased

WASHINGTON, D. C.—The International Emergency Food Council on February 21 announced international allocations of sugar which indicates that Americans will get 17 pounds of sugar per capita more this year than last. The council allotted to the United States enough sugar to provide 90 pounds of refined sugar per capita. Last year's allotment was 73 pounds and the pre-war consumption average 96 pounds.

The American share will be used to supply individual consumers as well as institutional and industrial users.

The Department of Agriculture and O.P.A. will decide how the allocation will be made among these classes of consumers. O.P.A. has already announced, however, that the individual ration allowance will be increased 5 pounds April 1. Last year individual consumers received 25 pounds through ration stamps with the remainder of the 73 pounds divided between institutional and industrial users.

Raise Payments to Hospitals for Polio Care

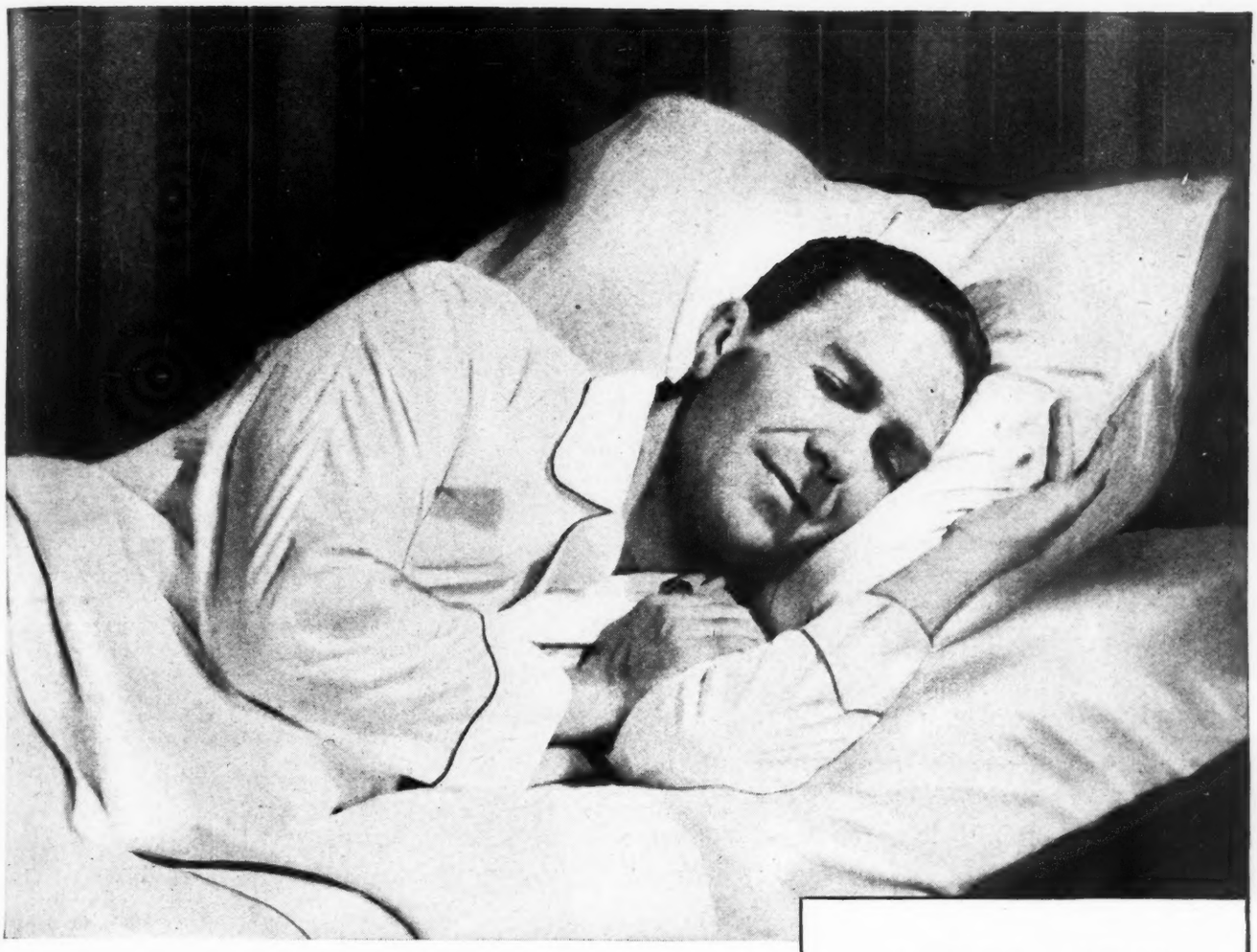
In recognition of increased hospital costs the Greater New York Chapter of the National Foundation for Infantile Paralysis has increased its payments to hospitals for the care of polio patients. The new plan establishes a ceiling of $10.50 a day for hospitalization, $4.50 for home care and $2.50 for clinic visits, as against the $7 for hospitalization, $3.50 for home care and $2 for clinic visits formerly paid.

Under this schedule, which has been endorsed by the Greater New York Hospital Association, the rate paid by the chapter will be the daily average ward cost as reported by each hospital annually to either the United Hospital Fund or the Greater New York Fund. In addition, hospitals will be paid for "extraordinary items of medical care" not included in the computed daily average ward cost.

Gypsies Disrupt Hospital's Calm

A band of Gypsies, enraged by the death on the operating table of their 300 pound "Queen" Mary George, battled attendants at Stetson Hospital, Philadelphia, on February 19. Led by "King" George Eli, who witnessed the operation through a window in an adjoining room, the tribe made an unsuccessful effort to reach the surgeon, Dr. Joseph O. Keezel. Dr. Keezel had attempted to dissuade the "Queen" from having the hernia operation, but she had insisted upon it.

After several details of policemen had routed the first band of Gypsies, who began a wailing chant as they retreated from the building, a second group of subjects arrived and staged a demonstration that also required patrolmen to restore order.



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Patient Load in V.A. Hospitals Increases

WASHINGTON, D. C.—The number of veterans hospitalized by the Veterans Administration has reached an all-time high, according to a V.A. announcement February 9. Up to January 22, a total of 119,845 veterans was receiving treatment in V.A. hospitals and homes and in voluntary hospitals under contract to the Veterans Administration.

The number of veterans hospitalized has been increasing, but the number awaiting hospitalization has declined, an official of V.A. explained. At the first of this year, only 22,385 veterans with nonservice connected disabilities were awaiting hospitalization, the smallest number since March 1946. The drop was attributed to an increase in the number of beds available in V.A. hospitals and to a more rapid turnover of patients because of improved medical treatment.

Of the nearly 120,000 patients under V.A. care on January 22, 90,470 were in V.A. hospitals; 15,298 in V.A. homes, and 14,077 in voluntary hospitals.

Practical Nurse Bill Under Consideration

A bill providing for licensure of practical nurses in California is now under consideration by the legislature there. Ethel Goldrick of the California State Nurses' Association explained the bill's provisions at a nursing meeting in Pasadena recently.

"If this bill is passed, no person will be able to practice practical nursing without a license after Jan. 1, 1951, which is the earliest date the bill can be put into effect," Miss Goldrick said. Nine months' minimum training will be required for licensure, she explained. Friends and members of patients' families would, however, be permitted to perform gratuitous nursing service under the bill.

Direction 3 to VHP-1

WASHINGTON, D. C.—Direction 3 issued February 11 officially records the list of criteria on which C.P.A. bases its approval or denial of applications under VHP-1. Except for modifications these criteria have been in effect since they were first announced shortly after the order was established a year ago. The standards under which the Civilian Production Administration reviews applications for hospital construction remain unchanged. The applicant must establish the fact that the hospital or the expansion of its facilities is essential, that the project is nondeferrable, or that it will not use appreciable quantities of scarce building materials needed by the Veterans' Emergency Housing Program.

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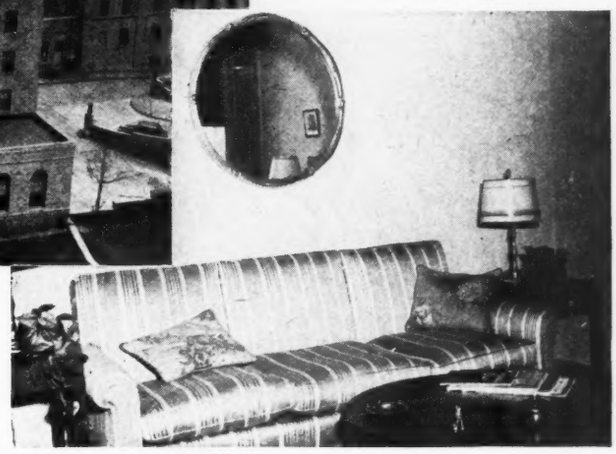
Photos: (Left): Exterior view Maxwell Hall. (Below): Living room, Senior Staff Member's apartment in new wing. (Center): Student's room. (Bottom): Kitchenette, Senior Staff Member's apartment.



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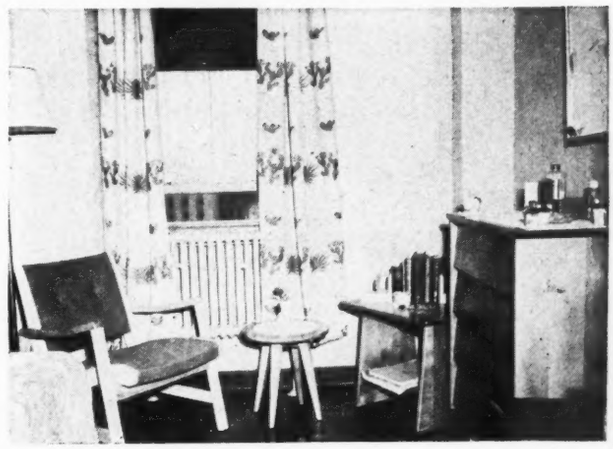
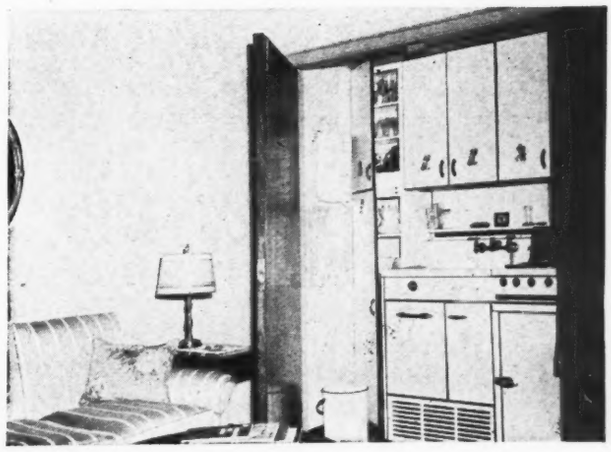
EMBRACING a group of specialized, therapeutic units, the Presbyterian Hospital, New York City, embodies in its organization and operation all that modern medical science and research have to offer today to aid its staff and patients. The two ten-story wings of Maxwell Hall, shown above, are the newest addition to the vast Columbia-Presbyterian Medical Center. Here are housed the entire student body and faculty of the Presbyterian Hospital's School of Nursing.



In decorating these new wings, Pratt & Lambert Paint and Varnish were used because of their outstanding beauty and low maintenance cost. The soft, pleasing authentic P&L colors contribute to a cheerful, refreshing atmosphere which largely accounts for their wide use in leading hospitals and institutions from coast to coast. Let us aid you in securing appropriate decoration with modern, therapeutic color and practical painting specifications. Pratt & Lambert-Inc., 126 Tonawanda Street, Buffalo 7, N. Y.



Cleveland Hospital Plan Called "Dictatorial"

In a difference of opinion arising out of cancellation of a member's contract in the Cleveland Hospital Service Association, the association was accused last month of "arbitrary and dictatorial" actions and subjected to investigation by the city's Industrial Relations Association, according to newspaper reports of the incident.

As reported, the Blue Cross contract of Damiano Caruso, an employe of the Electric Products Company, was canceled last September with no reason for the cancellation being furnished by the association.

In explaining the cancellation to Caruso's employer, the association said there was a "considerable mixup" about the amount of hospital care extended to Caruso, who had been a patient in more than one hospital under his contract. "The entire matter became so involved we decided our only recourse was to cancel the contract," an association official was reported to have said. "We did not do this because of its use, because we have always said that the object of the plan was to furnish hospital care, not to evade it."

In replying, Caruso's employer said, "I am of the opinion that an organization such as yours cannot afford indiscriminately to cancel contracts because of clerical difficulties experienced in handling them."

To this the association reportedly answered: "It would be absolute folly to allow 7000 accounts which the Cleveland Hospital Service Association services to dictate their own individual contracts."

The Industrial Relations Association took the view that Blue Cross had grown to be "a public utility, in general a fine thing for the people of the area and a necessity like certified milk or pure water" and therefore it was important that any unharmonious situations be cleared up promptly.

Lodge Bill Proposes Medical Aid to Needy

WASHINGTON, D. C.—Senator Lodge introduced a bill on February 24 to amend the Public Health Service Act so as to provide assistance to the states in furnishing certain medical aid to the needy and other individuals.

S. 678 would provide federal aid on a matching basis to those states which have a plan for making certain expensive medicines available to those who are entitled to them. Among medicines covered by the bill are: sulfa drugs, liver extract, insulin, mercury diuretics, endocrine products, vitamin preparations, typhoid vaccine, penicillin and streptomycin.

In introducing the bill Senator Lodge made it clear that he hoped additional medications used in other branches of medicine, such as dermatology and obstetrics, would be included.

In the field of medical service, the bill would provide federal aid on the same basis so that persons in need of them might obtain the use of such services as respirators and large scale x-ray facilities.

Announce Hospital Day Theme

The twenty-seventh observance of National Hospital Day will be celebrated with "Visit a Vet in a Hospital on National Hospital Day—and Remember Him Every Day" as its theme. Open house, radio and magazine publicity, community tours, visits to veterans by local and national figures, exhibits and commemorative programs honoring hospitalized veterans are expected to be included in the nationwide publicity campaign. Suggestions for complete Hospital Day programs, news releases and radio announcements have been prepared and are available through the Council on Public Relations of the American Hospital Association.

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One of these groups acts directly to counteract unpleasant odors often present in indoor air. The other group of substances in AIRKEM includes certain green plant extractives (commercial chlorophyll), use of which is a patented feature of the AIRKEM formula. This material is used in AIRKEM because its characteristic "green grass" odor, released at a concentration so low as to be unnoticeable as such, contributes to an odor undertone suggestive of the "freshness" of outdoor air.

There is nothing mysterious about this action. We know that outdoor air in pleasant surroundings has a characteristic odor undertone, though we are not consciously aware that it "smells nice". The AIRKEM formula seeks to create a similar appeal to the senses indoors, without arousing a conscious realization that this air carries an odor at all.

If you are not already a user of AIRKEM, try it. The pint bottle, with its new, self-spreading wick costs only $1.50. By the dozen, the price per bottle is $1.35, and half-gallon refills are still more thrifty.

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Government Formula to Be Discussed at Accounting Institute

The new government reimbursable cost formula for hospitals will be among topics discussed at the Institute on Basic Accounting and Business Office Procedure to be sponsored by the American Hospital Association April 14-18 in Chicago.

The new formula will cover government payment to hospitals for the care of veterans and their wives and infants formerly covered under the Emergency Maternity and Infant Care Law.

Other subjects to be discussed by hospital accounting experts will include organization of the accounting department, banking and payroll practices, credit and collection practices, accounting for auxiliary activities, prevention and detection of fraud and theft, how to prepare and use a budget and the value of uniform accounting and statistical methods.

Hospital administrators, accountants, bookkeepers and others employed in the accounting and business offices of association member hospitals are eligible to attend the five day institute. Personal members of the association also are eligible.

William H. Markey Jr., A.H.A. accounting specialist, is in charge of the institute.

Delay Completion of Georgetown Hospital

WASHINGTON, D. C.—Work on the new Georgetown Hospital here has been held up for seven weeks because of a jurisdictional dispute between two A.F. of L. unions, according to information released February 20.

The dispute is keeping a minimum of 10 members of the sheet metal workers union from installing air conditioning equipment. Carpenters and joiners contend that installation of "cabinets" or "lockers" in the hospital's 400 rooms is their work. The metal workers maintain that such installation falls within their province.

Consequently, the carpenters have gone ahead with the disputed job and the metal workers have refused since January 3 to put in air conditioning units.

Consider Hospital in L.A.

A $1,500,000 crippled children's hospital in Los Angeles is under consideration by the imperial divan of the Shriners, it has been announced. The divan, which corresponds to a board of directors, is also considering the addition of a children's clinic to the Houston Medical Center, Houston, Tex.

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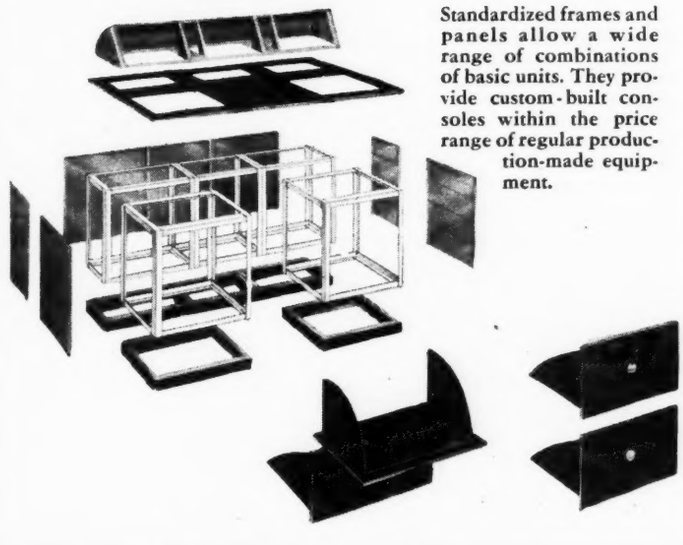

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Approve Plans for 750 Bed V.A. Hospital in District of Columbia

By EVA ADAMS CROSS

WASHINGTON, D. C.—Preliminary plans for the Veterans Administration 750 bed general medical and surgical hospital for this area have been approved by V.A. and the army engineers, the War Department announced February 8. The $15,000,000 hospital will be located on the Nevius tract, a 27 acre site just north of the Arlington National Cemetery. The site is a continuation of the axis of the Mall and it has a strategic location with respect to the plan of the national capital.

The nine and one half story structure, though commanding a superb view of the city, will not compete with the dignity of the Lincoln Memorial. It is planned to fulfill the functional needs of a hospital without becoming too formal or monumental.

Upper stories will be T shaped in plan with two nursing units per floor facing east, overlooking the Potomac River and Washington, and one nursing unit per floor facing south. Each nursing unit will occupy an entire wing of the T shaped plan and the typical nursing unit will provide accommodations for 40 patients of whom 16 will be in a large ward, 12 in four bed wards and 12 in single rooms.

The third floor will contain operating rooms, a recovery suite, a surgical nursing unit and a cardiovascular nursing unit. Laboratories, x-ray department, physical and occupational therapy, staff quarters, main kitchen and patients' cafeteria and the canteen and patients' recreational facilities will occupy the second floor. The outpatient department, emergency and admitting rooms, administrative offices, service organizations, chapel, auditorium and general storage facilities are planned for the first floor.

General service facilities will be grouped together in a separate building containing the heating plant, incinerator, laundry, shops and garage. There will be individual buildings to house attendants and nurses and five residences for staff officers.

It is estimated by V.A. officials that the hospital will not be completed for some two years or more. The hospital is being designed by Louis Justement of Washington and by York and Sawyer of New York City.

Urge Negro Physicians at Gallinger Hospital

WASHINGTON, D. C.—The District of Columbia Physicians' Forum started a campaign here February 15 to obtain staff and teaching privileges for Negro physicians at Gallinger Hospital. The group also sought immediate action on recommendations made last year by the Metropolitan Health and Hospital Survey.

An open letter to Dr. Herbert P. Ramsey, chairman of the Metropolitan Health Council, requested the council to take immediate steps to implement those recommendations of the survey report that deal with the Health Security Administration, the licensing of District hospitals, the expansion and reorganization of the health department and the elimination of racial discrimination regarding the Gallinger Hospital staff.

Gift Honors Chief of Staff

Monmouth Memorial Hospital, Long Branch, N. J., has received an anonymous gift of $100,000 toward the construction and equipment of a surgical floor in honor of Dr. Harry B. Slocum, chief of staff. The surgical floor will be part of a new wing which is planned to add to the hospital's facilities. Dr. Slocum, a lifelong resident of Long Branch, has been affiliated with the hospital since 1901. He became chief of staff in 1922.

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Approve Addition to St. Elizabeth's Hospital

WASHINGTON, D. C.—A $1,650,000 addition to St. Elizabeth's Hospital was approved February 19 by C.P.A. The application was submitted by the Public Buildings Administration and strongly recommended by the U. S. Public Health Service. Approval was granted on the basis of public health and safety to prevent a serious breakdown in facilities which now serve some 6300 patients.

The hospital's present laundry building, designed to handle 3,000,000 pieces a year, is now taking in more than 13,000,000 pieces annually. Proper washing and sterilizing are difficult with present facilities.

The new construction calls for a five story building housing laundry, warehouse and shops. It will provide a tailor shop; a shoe shop for manufacturing and repair of patients' shoes and other leather items; a shop for manufacturing, repairing and sterilization of mattresses, and storage space for food and other supplies.

St. Francis Hospital Launches First Appeal

For the first time in its forty-seven year history, St. Francis Hospital, Evanston, Ill., is making a public appeal for funds to raise $1,375,000 for an addition to the main building. The program was started in 1945 but was postponed because of postwar reconstruction problems.

The contemplated wing will consist of four stories with basement and will adjoin the main structure. It is designed to provide for a modern social service department, new and expanded laboratory, intern quarters and communicable disease department. The total bed capacity will be increased from 404 beds, including 74 bassinets, to 474 beds.

Plans for the new building were drawn under the direction of Herman J. Gaul and Son, architects who designed the existing structure. Sister Mary Florina is the administrator.

Work to Start on New Hospital

Work is scheduled to start this month on construction of the new Stickney Hospital, Stickney Township, Ill., it has been announced by Charles J. Vokoun, secretary. Plans have been drawn and the construction contract has been awarded for the five story building, which will be erected on a 10 acre tract. Permission has been granted by the Civilian Production Administration to build a $680,000 building, but it is estimated that the completed structure will cost approximately $1,000,000.

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Food and Drug Group Reports New Drugs Cleared for Distribution

WASHINGTON, D. C.—A total of 114 new drugs was cleared for distribution during the last fiscal year, according to the report submitted February 7 by Commissioner Paul B. Dunbar of the Food and Drug Administration. Among these are some products resulting from medical research for our armed forces. Increased facilities for research and production have resulted in many other worthwhile additions to our weapons to combat disease, the report stated.

Predistribution testing of penicillin, which was the Food and Drug Administration's responsibility under wartime controls, continued under the penicillin amendment to the Food, Drug and Cosmetic Act. All lots of streptomycin manufactured in the fiscal year were tested by the administration under allocation orders of C.P.A. Commissioner Dunbar recommended the continuance of this type of predistribution testing after allocation controls end through an amendment to the law identical with that which authorizes pretesting of penicillin.

Violative sales of prescription drugs resulted in some 14 criminal prosecution actions and two injunction cases against retail druggists in 1946. Included in the sales were sulfonamides, thyroid, barbiturates and penicillin, all shipped under labels limiting sales to physicians' prescriptions but sold to laymen without prescriptions. The health of the consumer was seriously jeopardized in the cases brought to federal court.

The misbranding of medicines with false curative claims on the carton and bottle labels has been largely corrected, according to Commissioner Dunbar. "Those who attempt to misrepresent their products tend to use less conspicuous types of labeling, such as circulars which may be stored in separate packages until they are ultimately brought together with the medicine on the dealers' counters, or oral promotion in a modern counterpart of the oldtime medicine show," the commissioner explained.

When metals became available, the marketing of gadgets and contraptions misbranded with claims for the cure of serious diseases showed a sharp increase. Sixty-nine shipments of devices, selling for amounts ranging up to $6500, were seized. The diseases they purported to treat or cure included diabetes, cancer, tuberculosis, syphilis, arthritis, blood-poisoning, sinus and bronchial troubles.

Penicillin Production Up

WASHINGTON, D. C.—The monthly rate of penicillin production more than doubled during 1946, C.P.A. said February 18. The total output for the year was 25,808.57 billion Oxford units. So satisfactory was the climb in the production rate that government allocation of penicillin was discontinued December 31. Export restrictions were removed at the same time. Domestic demand for the drug is being met adequately and substantial quantities are available for shipment abroad. There is no indication of future need for renewing distribution controls. The Penicillin Industry Advisory Committee will not be dissolved until later this year, however, as a safeguard against any emergency.

Hospitals Train Nurse's Aides

In an all out campaign to obtain nurse's aides for Chicago hospitals, the Council of Social Agencies there is giving a training course for women in the Mount Sinai, St. Luke's and Michael Reese hospitals. The course is aimed at providing training in such simple nursing procedures as tray service, bed making, pulse and temperature recordings and other minor bedside routines. Trained volunteers will be assigned for hospital duty after they have completed the course, according to Mrs. Evelyn S. Byron, council director.

American Theatre Wing Starts Recreation Plan for V.A. Hospitals

Recreational programs for the neuropsychiatric hospitals of the Veterans Administration are to be established by the American Theatre Wing's hospital committee. The project will employ specialized entertainment technics proved by the Wing in its morale contributions to servicemen and veterans in 35 hospitals in the New York metropolitan area in the last four years.

A dozen stage and radio actresses have taken a course of training that will prepare them to demonstrate recreational technics to staff workers and volunteers of veterans hospitals all over the country. The 12 actresses will tour the country in four teams of three each from March 31 to the middle of June. Each unit will serve about eight hospitals in its assigned area and will stay five days in every hospital visited.

The actresses taking part in the project received ten days' training. Each unit lived in a hospital to learn about conditions there from the patients' point of view. For the first five days they studied with psychiatrists and special service officers; the second five days were devoted to practical application of Wing recreational methods.

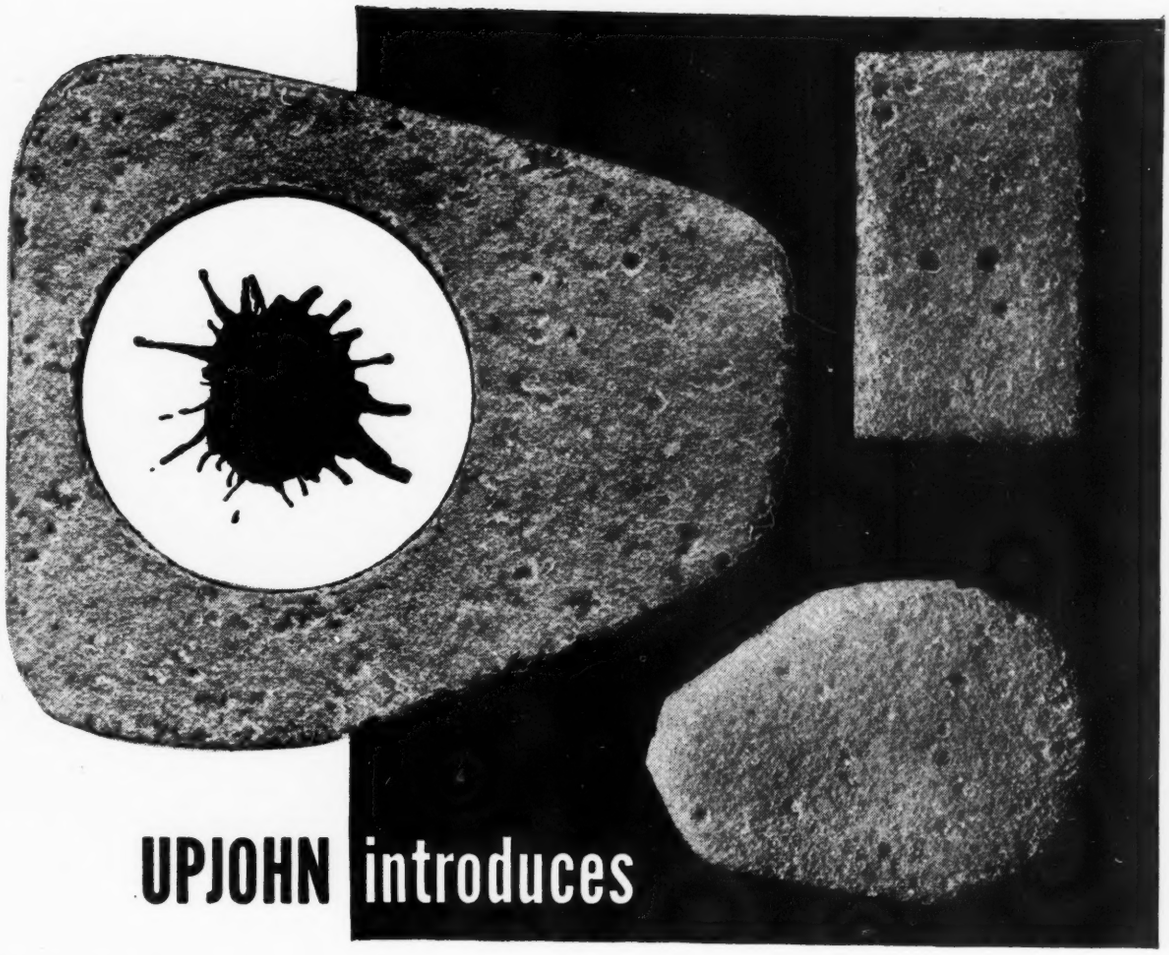
$1,000,000 Fund Aids Hypertension Research

A $1,000,000 foundation for research in hypertension has been established at Beth Israel Hospital, New York, according to a recent announcement by Dr. Maxwell S. Frank, medical director of the hospital. The foundation was set up with a gift from Mr. and Mrs. Joseph Levy and is incorporated as "The Joseph and Helen Levy Foundation in Memory of Miriam Levy Finn."

Research in hypertension and other fields made possible by the endowment will be coordinated with the scientific work of other recognized medical institutions. One objective of the foundation, Doctor Frank added, will be to furnish research opportunities for young physicians and scientists with inclinations toward investigations in medicine.

Opens Psychiatric Floor

A 30 bed psychiatric unit, with laboratories and other treatment facilities, has been opened by Mercy Hospital, Chicago, which is the sixth voluntary hospital in the Chicago area to open such a unit. The department will be headed by Dr. John Madden, chairman of neurology and psychiatry at Loyola University, with Dr. J. A. Luhan, clinical professor of psychiatry at Loyola, as his associate.



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Hold Regional Meeting to Plan State Needs Under New Law

By EVA ADAMS CROSS

WASHINGTON, D. C.—The fifth regional meeting to review and clarify instructions for developing state plans for a hospital construction program under the Hospital Survey and Construction Act will be held in Kansas City, Mo., March 18 and 19, according to Dr. J. C. Haldeman, chief of the office of program operations of the Hospital Facilities Division, U.S.P.H.S. Other such meetings called by the district offices of the Public Health Service have been held in Denver, Richmond, New Orleans and New York City.

These conferences, attended by personnel of state agencies responsible for the administration of the program and by officials of the Hospital Facilities Division, cover details of every step in developing a state hospital construction program. To benefit under the act, each state is required to set forth a plan based on a statewide inventory of existing hospitals and survey of need.

Some 40 states will have legislatures in session this spring, and it is expected that enabling legislation will be enacted, provided that compliance with minimum standards of maintenance and operation shall be required in the case of hospitals which shall have received federal aid under the act. If any state has not passed such legislation prior to July 1, 1948, it will not be entitled to further allotments.

Under the plan hospitals must be available without discrimination on account of race, creed or color. Where separate hospital facilities are provided for separate population groups, an exception may be made, but the plan must make equitable provision for facilities and services of like quality for each group.

The nine Public Health Service districts and the states included in each are as follows:

1. *District 1—15 Pine Street, New York 5:* Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont.
2. *District 2—State Planters Bank Building, Richmond 19:* District of Columbia, Maryland, North Carolina, South Carolina, Virginia, West Virginia.
3. *District 3—610 South Canal Street, Chicago 7:* Kentucky, Illinois, Indiana, Michigan, Ohio, Wisconsin.
4. *District 4—707 Pere Marquette Building, New Orleans 12:* Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Tennessee.
5. *District 5—1604 U. S. Appraisers' Building, San Francisco 11:* Arizona, California, Nevada, Oregon, Washington, Alaska, Hawaiian Islands.
6. *District 6—San Juan, P. R.:* Puerto Rico, Virgin Islands.
7. *District 7—417 East Thirteenth Street, Kansas City 6, Mo.:* Kansas, Iowa, Minnesota, Missouri, Nebraska, North Dakota, South Dakota.
8. *District 8—Room 615, Colorado Building, Denver 2:* Colorado, Idaho, Montana, Utah, Wyoming.
9. *District 9—513 Santa Fe Building, Dallas 2, Tex.:* Texas, New Mexico, Oklahoma.

A.H.A. Board of Trustees Approves Three Plans

Approval by the board of trustees of the American Hospital Association has been extended to South Carolina Hospital Service Plan, Greenville, S. C.; Memphis Hospital Service Association, Memphis, Tenn., and Wyoming Hospital Service, Cheyenne, Wyo., the Blue Cross Commission announced March 1. This makes Blue Cross protection available in 46 states, according to Richard M. Jones, acting Blue Cross Commission director. The South Carolina and Wyoming plans will operate on a statewide basis, and the Memphis plan will cover the Memphis metropolitan area.

Approval of the new plans, together with reapproval of all existing plans, brings the total number of Blue Cross plans in the United States, Puerto Rico and Canada to 89. Total membership in these plans is now 26,000,000.

Standardization Means Economy, Physician Tells Purchasing Group

A committee representing surgeons, nursing staff and administration can effect standardization of operating room equipment and supplies, use of efficient material and conservation of nursing time with the result that more procedures can be performed with maximum safety, Dr. Benjamin Etsten, chief of anesthesia at Albany Hospital, Albany, N. Y., told the American Hospital Association Institute on Hospital Purchasing in Chicago the week of February 10.

"Success in the standardization of equipment and procedures in an operating room depends upon the combined cooperation of surgeons, anesthetists, nurses and administration," Doctor Etsten declared. "Surgeons are best qualified to determine requirements for instruments, lights and operating tables. The nursing staff can estimate the labor and time needed for collection, sterilization and preparation of instruments, drapes and sponges for various operations. The administration can best evaluate the combined recommendations of the surgical and nursing staff as to practicality and economy."

Dr. Etsten described how such a committee has effected simplification and economy in his hospital.

The institute attracted more than 150 registrants from 22 states. About 40 per cent of those attending were full time hospital purchasing officers; another 40 per cent were administrators, and the remainder were dietitians, business managers, pharmacists and department heads.

A novelty at this institute which was welcomed by most of those in attendance was the elimination of the concluding banquet and the substitution instead of a buffet supper and social hour on the first evening of the week.

Registrants were also given an afternoon off to visit points of interest.

Announces Summer Courses

Cornell University has announced that its regular summer school short courses in hotel administration will begin this year on June 23. The courses are designed especially for hotel and restaurant employes and include menu planning, food and beverage control, hotel operation, food production planning, hotel stewarding, sales promotion, quantity food preparation, personnel methods, housekeeping, interpretation of financial statements, elementary accounting and hotel accounting. Veterans entitled to the benefits of the G.I. Bill may enroll at government expense, the announcement said.

Underground Parking Lot Proposed for New Mercy Hospital

An underground parking lot—first of its kind in the Chicago area—is one of the unusual features of the proposed $10,000,000 Mercy Hospital now being planned for construction on the Northwestern University medical school campus in downtown Chicago.

The lot will be three tiers deep and is planned to include one automobile for every two hospital patients, the accepted rule of thumb for estimating hospital parking requirements, according to Carl Erikson, architect. Construction of the underground facilities is necessary because of congested traffic and parking conditions in the area where the hospital will be located.

The Sisters of Mercy now operating Mercy Hospital on Chicago's south side are planning an intensive fund raising campaign for the new project to be undertaken immediately under the general chairmanship of Edward J. Kelly, mayor of Chicago.

Hospital Council Has Master Plan

A master plan for hospital and related facilities in New York City, as recommended by the Hospital Council of Greater New York, proposes a system of community, regional and central hospitals for general care, medical education and research with a ratio of four general hospital beds per one thousand New York residents. The master plan was announced publicly in New York February 27. It adapts to the New York area the type of integrated interlocking system of regional and central hospital facilities recommended by the Commission on Hospital Care.

"With the trend toward voluntary insurance plans and group practice, there is no assurance that ward patients will continue to represent the major proportion of hospital patients," the council's announcement said, pointing out that provision must be made to include semiprivate and private patients in residency training programs in hospitals.

Urge Hospital for Alcoholics

A bill providing for establishment of a state hospital for alcoholics was introduced in the Illinois state legislature last month. The hospital would cost $900,000 and would be located in Chicago on a site chosen by a special governor's commission appointed for the purpose. It would provide facilities for 500 resident patients and 2000 outpatients.

Hahnemann Hospital Quits Philadelphia Plan in Payment Dispute

A dispute centering on payments to hospitals by Associated Hospital Service of Philadelphia broke out there last month when the Hahnemann Hospital, claiming a loss of $40,000 on Blue Cross patients in a year's operation, announced its intention to withdraw from the plan.

Following the announcement, it was disclosed that negotiations between Associated Hospital Service of Philadelphia and the Philadelphia Hospital Council, which represents 53 of the 68 member hospitals in the plan, had been in progress for several months. Hospital council representatives said the negotiations for a new scale of hospital payment had been carried on amicably with a view to establishing new rates by an April 1 deadline.

Replying publicly to Hahnemann Hospital's charges that current Blue Cross losses were at the rate of 20 per cent of billing, Thomas S. Gates Jr., Blue Cross president, said, "Such billing losses assume that every patient would, had he not been a Blue Cross subscriber, have paid every cent billed by the hospital, which is nonsense."

Mr. Gates pointed out that Blue Cross made two increases in its hospital payment rate in 1946. "Blue Cross has made two offers to the hospital council which would get away from payments geared to billings of individual hospitals," Mr. Gates continued, "but both have been turned down by the council. Variance in hospital charges for such procedures as urinalysis is as much as from one to ten. No standard basis of payment can be made to satisfy all with such wide variations.

"Associated Hospital Service has been willing to recommend an increase in subscriber rates to the Insurance Commission. However, the board of directors has earnestly sought for a basis of payment to hospitals which would have greater long term satisfaction in hospital-Blue Cross relations than the present scale of payments, in which the hospitals measure the adequacy of Blue Cross payments by the total billing made for the care provided.

"Blue Cross is sympathetic to the hospitals' problem. Their costs have been enormously increased. Yet it cannot be unmindful of the fact that it will be very difficult to sell Blue Cross coverage at much higher rates. Blue Cross welcomes public discussion on this public matter," Mr. Gates concluded.

Resolution Recommends Federal Aid for Nursing Education

A resolution recommending federal assistance for nursing education was passed by the Council for the Coordination of Medical, Hospital and Nursing Services of the Kansas City area at a meeting last month.

The resolution stated in part: "Federal subsidy of tuition and possibly other expenses will enable many young women to enter the nursing field who cannot now afford it and will otherwise accelerate recruitment. A national and local nursing emergency exists and promises to become worse. A severe crisis is imminent in the hospitals' ability to care for the sick. It is recommended that similar action be considered by medical, nursing, hospital and civic organizations."

Hospitals that prepare nurses not only for their own staffs but also for public health, industry, doctors' and clinic offices and private duty should not bear the full cost of this education, the council felt.

The coordinating council is an organization composed of delegates from the Jackson and Wyandotte County Medical Societies, the local nursing associations and the Kansas City Area Hospital Council.

Social Security Board Report Calls for Extension of Coverage

WASHINGTON, D. C.—The eleventh annual report of the Social Security Board submitted February 11 called for medical care insurance through federal legislation as the "simplest, most economical and most effective basis" for keeping the nation in good health. This recommendation followed closely President Truman's stand for a national health program.

The report held the problem of paying for adequate medical care equally as important and serious as the wage loss from disability. It recommended provision under federal law for cash benefits to insured workers and their dependents during both temporary disability and extended disability; insurance against costs of medical care, including payments to physicians, dentists, nurses, hospitals and laboratories, with provision for decentralization of administration and utilization of state administration.

The report stated that there is general agreement on the desirability of a large governmental contribution to the cost of keeping the nation in good health; the major difference of opinion is in deciding the most appropriate way of making it. Free care on a means test basis, the board believes, is not the solution. The great majority of normally self supporting persons can and would prefer to pay for their medical care through some system of prepayment that distributes costs over groups of people and periods of time, rather than seek free care after they have been reduced to dependency.

Establishment of a comprehensive system of social insurance to form an expanded federal old-age and survivors' insurance and unemployment insurance system was also recommended. Also proposed was the establishment of a comprehensive program of public assistance on a federal-state basis under which financial help would be given to needy persons, irrespective of the reason for need or the place of residence.

Federal financial participation was advised in the costs of medical services made available to needy persons under state public assistance programs and in assistance payments to needy sick persons who reside in public or private medical institutions other than mental hospitals and tuberculosis sanatoriums.

Bills Seek to Revise Army Medical Department

WASHINGTON, D. C.—Identical bills were introduced in both Houses of Congress in February to revise the medical department of the army. Title I of the proposed legislation would establish a medical service corps in the medical department of the regular army. This new corps would consist of the pharmacy section, the medical allied science section, the optometry section and any other sections deemed necessary by the Secretary of War.

Title II would establish an army nurse corps. The authorized strength of this corps would be in the ratio of six members to every 1000 persons of the total authorized strength of the regular army. The minimum authorized strength of this corps would be: 18 officers in permanent commissioned grade of lieutenant colonel; 40 officers in permanent commissioned grade of major; 2500 other officers in permanent commissioned grades of captain to second lieutenant, inclusive. The chief of the army nurse corps would have the temporary rank, pay and allowances of a colonel.

Title II would also establish a women's medical specialist corps to consist of a dietitian section, a physical therapist section and an occupational therapist section. Permanent commissioned rank would be accorded the officers of the corps except the chief, who would have the temporary rank of colonel.

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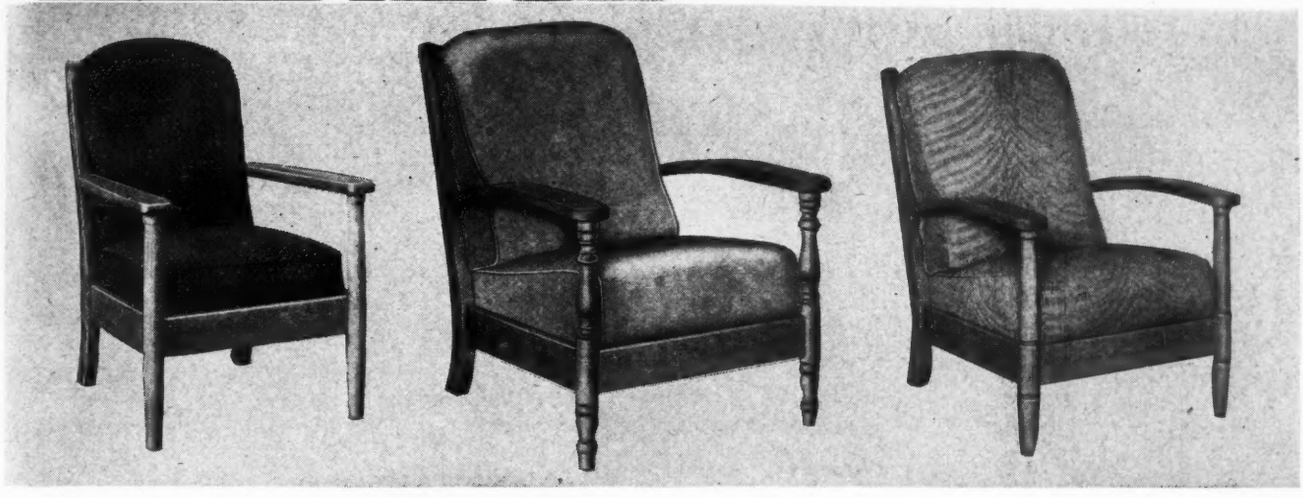

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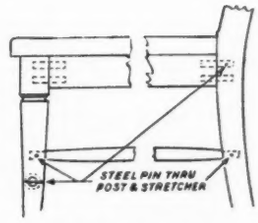

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WOOD FURNITURE FOR HOSPITAL SERVICE

Evanston Hospital Launches Campaign for $5,000,000 Fund

A $5,000,000 expansion program for the Evanston Hospital Association, Evanston, Ill., was announced by the hospital's board of directors last month. The new facilities are needed to provide the hospital service required by the growing population of the north suburban area of Chicago, the announcement said.

Needs of patients have taxed the hospital's facilities to the fullest and have shown that additional buildings are urgently called for, Robert T. Sherman, hospital president, declared. "The strain of emergencies, such as the recent poliomyelitis epidemic, shows us clearly that we must begin building immediately," he said.

The expansion program is called "The North Suburban Hospital Plan." The first step will be the erection of an 80 to 100 bed addition to provide for the most urgently required additional space. Every effort is to be made to break ground for it by June 1947, Mr. Sherman said.

Succeeding steps in the expansion program include new facilities for pediatrics and obstetrics and additional units for tuberculosis, psychiatry and chronic disease services.

On the first announcement of the campaign, doctors on the staff of Evanston Hospital joined together in pledging substantial financial cooperation, according to Mr. Sherman. Several lay friends of the hospital have already given checks for large amounts. As the campaign opens, it appears that approximately $500,000 has been contributed, or about 40 per cent of the amount needed for the first building.

N. Y. Health Council Sets up Committee to Integrate Service

An integrated plan for voluntary health agencies which will assure maximum service by all such agencies in the New York area is the aim of a special committee set up by the Health Council of Greater New York, Dr. I. Ogden Woodruff, president of the council, announced March 3.

Members of the committee are: Dr. Howard Reid Craig, director of the New York Academy of Medicine; Bailey B. Burritt, president of the New York Tuberculosis and Health Association and an associate chairman; Dr. Thomas D. Dublin, professor of preventive medicine and community health of Long Island College of Medicine.

"The scope of the work of the committee is so broad that everyone concerned agreed we would achieve best results with a team working together to develop the program and we have been fortunate in getting these three prominent men as co-leaders to assist the health council in its efforts to achieve effective long range health planning," Dr. Woodruff said.

"There are indications that the next few years will bring a tremendous upsurge in health service and education and for this reason it is of the utmost importance that we be fully prepared to meet the new demands with modern thinking and modern weapons," Dr. Woodruff concluded.

A schedule of meetings is planned for the new committee which will confer with representatives of voluntary health organizations on their present activities and future programs and plan with them their study of needs in the various health fields they represent.

84 Medical Plans Now Operating in 33 States and D. C.

A total of 84 medical prepayment plans operating in 33 states and the District of Columbia was reported by tht Council on Medical Service of the American Medical Association in its February 24 *News Letter*. In addition, the report said, medical groups in eight states have reached "a fairly definite planning stage" in the development of their prepayment programs and seven more state groups are reported as "working on prepayment."

Complete enrollment figures for the last year are not available, the council reported, but a number of plans reported enrollment increases of more than 100 per cent for 1946 and one plan, Surgical Care of Milwaukee, reported an increase of more than 1000 per cent.

The largest medical prepayment plans listed by the council, together with estimated membership, are:

Michigan Medical Service	850,000
Massachusetts Medical Service	461,000
California Physicians' Service	419,672
United Medical Service, New York	405,744
Washington State Medical Bureaus	360,000
Hospital Saving Association of North Carolina (Chapel Hill)	178,889
Colorado Medical Service	174,132
Hospital Care Association and Medical Service Association of Durham, N. C.	138,704
Hospital Service Association, Oakland, Calif.	116,653
Surgical Care, Inc., Kansas City, Mo.	114,186
Western New York Medical Plan, Buffalo	100,281
Oregon Physicians' Service	100,000

Five Point Expansion Program Announced by Chicago Hospital

A $3,500,000 fund raising program to finance building expansion for St. Luke's Hospital, Chicago, was announced March 2 by officials of the hospital board. Units of the building program will be undertaken one at a time as funds become available. The announcement said that all hospital organizations, including the medical staff, women's board, women's auxiliary and alumnae association, are aiding in the fund raising effort.

Steps in the building program include:

1. Relocation of the pharmacy from its present site in the old hospital building to a more centrally located place in the main building.

2. Construction of a clinical building of three stories with a foundation for later completion of five additional stories for use by the outpatient department.

3. Installation of complete new kitchens, cafeteria, dining room facilities.

4. Additional facilities for housing student nurses and graduate staff nurse personnel.

5. New medical service building of five stories with provision for seven additional stories.

The new building will provide for expanded laundry, kitchen and dining room facilities, centralization of operating rooms and consolidation of all obstetrical facilities.

Operations Televised at Johns Hopkins

A television broadcast of an actual operation to test the practicability of this means of surgical teaching was presented February 27 by the Johns Hopkins University and Hospital in cooperation with the Radio Corporation of America.

The purpose of the experiment was to permit members of the Johns Hopkins medical and surgical association to witness operations by television during a two day reunion of the association. The experiment was arranged by Dr. I. Ridgeway Trimble and Dr. Frederick M. Reese, members of the hospital's staff, with the approval of Dr. Edwin L. Crosby, director of the hospital. Representation was restricted to receivers in rooms on the operating floor of the hospital, as the telecast was designed for doctors and surgeons only.

The first operation, televised February 27, was a so-called "blue baby" operation. Other operations were televised on suceeding days of the conference.

Commenting on the experiment, Dr. Crosby said, "Adequate observation facilities to teach surgical technics have long been a serious problem. The physical limitations of amphitheaters sharply restrict the possibility of the operative field. Television has brought the operative field within the critical sight of large numbers of doctors and students and will permit them to witness many operations. The experience, although short, with this experiment, indicates that television may be extremely valuable in this type of teaching."

Two super-sensitive cameras were used in the experiment, Dr. Crosby explained. One was mounted on the operating room light fixture directly above the operating field. This permitted a detailed view of the operation. The second camera, equipped with a telephoto lens, was set up in the gallery of the amphitheater.

Women Back Infirmary Drive

More than $1,000,000 of the $5,000,000 sought by the New York Infirmary for Women and Children, New York City, has been collected or pledged, Evelyn Blewett, executive director of the fund, reported February 27. Women's organizations, such as the New York City Federation of Women's Clubs and the New York State Federation of Business and Professional Women's Clubs, have given active support to the project.

Surgeon's Scrub-Up Room St. Monica's Hospital, Phoenix, Arizona

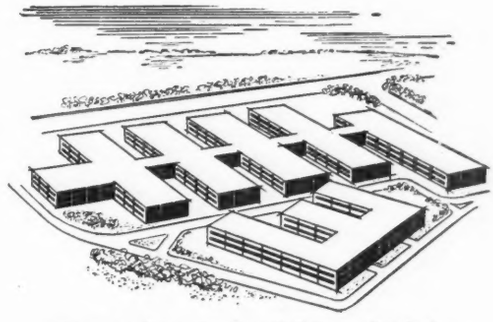
Duraclay *

Choice of St. Monica's Hospital

In no other service must plumbing fixtures stand the tough usage to be expected in hospitals. To meet these conditions Crane Co. developed Duraclay—an all-ceramic material that has proved its superiority in many of the nation's leading institutions. For instance, in St. Monica's Hospital at Phoenix, Arizona, Duraclay fixtures are on duty twenty-four hours a day, providing the asepsis so essential in such service. Wherever installed, Duraclay has proved its value because

- ★ Duraclay is resistant to thermal shock—sudden extreme changes in temperature do not affect it.
- ★ Duraclay will stand abrasion and strong acids. It is not subject to staining.
- ★ Duraclay has a hard glazed surface that resists soiling and is easily cleaned with a damp cloth.

* ***Duraclay*** exceeds the rigid tests imposed on earthenware (vitreous glazed) established in Simplified Practice Recommendations R106-41 of the National Bureau of Standards.



"In 1943 there were installed in our hospital a quantity of Crane Duraclay plumbing fixtures which have been in continuous use since these facilities were opened. We have had excellent results from these fixtures."

C. H. Linville
Business Manager
St. Monica's Hospital
Phoenix, Arizona

CRANE

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NATION-WIDE SERVICE THROUGH BRANCHES, WHOLESALERS, PLUMBING AND HEATING CONTRACTORS

245,000 Enrolled in U.M.S. During 1946

Enrollment of 245,000 persons in United Medical Service of New York during 1946 represented an increase of 152 per cent over 1945 enrollment and brought the total to more than 400,000, it was announced in February by Rowland H. George, president. The increase placed United Medical Service among the largest from an enrollment standpoint of the 45 Blue Cross affiliated medical service plans which now serve an aggregate of 4,185,872 persons.

According to Mr. George, 11,668 physicians representing at least six out of 10 physicians in the Greater New York area now cooperate with United Medical Service. In four counties, 100 per cent of the medical profession engaged in active practice participates.

"At the end of two and one half years," said Mr. George, "we can point to a satisfactory record. Our financial foundations are sound and enrollment is steadily increasing. The promises we made to the public have been more than fulfilled. We are particularly proud of the fact that our doctors have agreed to accept United Medical Service payments as full compensation for services to members in the low income brackets. Having sponsored United Medical Service through their organized medical societies, they are cooperating in every way possible and the public is showing increasing confidence in their plan for voluntary prepaid medical care."

Geisinger Hospital Starts Bone Bank

A "bone bank" to provide a constant supply of bone for grafting operations has been established at the George F. Geisinger Memorial Hospital at Danville, Pa., the hospital announced February 22. Dr. Leonard F. Bush, head of the hospital's orthopedic department, described the bank in a talk before the New York Academy of Medicine's orthopedic section in New York City.

The "bone bank," one of the first of its kind in the United States, was established on recommendation of Dr. Bush, who spent considerable time at New York Orthopedic Hospital experimenting with human bones which had been kept under deep freeze for extended periods. Already several successful bone grafting operations have been performed with the use of bone from the Geisinger Hospital, Dr. Bush said. He added that he expects the system will prove so useful that other medical centers doing extensive orthopedic surgery will set up similar facilities.

Principal value of the "bone bank," Dr. Bush told the New York group, is that it eliminates the delay of having to perform simultaneous operations to remove the bone from a bone donor and transplant it in the person needing the extra bone. Under the new plan, bones obtained from operations in which extra bone is removed are sterilized and then kept in a deep freeze unit at 10°F. until needed. Bones will keep indefinitely this way, he asserted.

Medical Library Group to Meet in Cleveland

The forty-sixth annual meeting of the Medical Library Association will be held in Cleveland May 27-29, according to an announcement made by Heath Babcock, association secretary.

Speakers on the scientific and educational program of interest to hospital and medical record librarians include Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*; Tom Jones, professor of medical and dental illustration at the University of Illinois; Dr. Bruno Gebhard, director of the Cleveland Health Museum, and Seymour Robb, librarian at Columbia College of Physicians and Surgeons.

Bills to Establish Science Foundation Again Before Congress

By EVA ADAMS CROSS

WASHINGTON, D. C.—A rash of bills in February marked the renewing of the drive in Congress to establish a National Science Foundation. J. Alexander Smith introduced on February 7 a bill, S. 526, to establish such a foundation which he claims avoids many of the controversial issues which helped to defeat the Magnuson-Kilgore measure last year. Mills introduced an identical bill on February 10 in the House. Co-sponsors of the Senate bill were Senators Fulbright, Magnuson, Cordon and Revercomb.

The Smith bill would establish a National Science Foundation with 48 members to be appointed by the President. The 48 member plan, explained Senator Smith, has nothing to do with the number of the states and might be reduced if it were found too bulky. The persons nominated would be outstanding men and women who are recognized leaders in the fields of the fundamental sciences —medical, engineering, education and public affairs.

The foundation would be authorized to develop and encourage a national policy for scientific research and education. The authorization would cover responsibility in initiating and supporting basic scientific research in connection with the national defense and welfare; the granting of scholarships and fellowships; the fostering of an interchange of scientific information among scientists in the United States and foreign countries, and the correlation of the foundation's scientific research programs with those undertaken by individuals and by public and private research groups.

Broad powers are given in the Smith bill to an executive committee of nine members. This committee would appoint a director at a yearly salary of $15,000 and prescribe his powers and duties. The bill, purportedly drawn up with the help of Dr. Vannevar Bush, James B. Conant, president of Harvard, and H. D. Smyth of Princeton, makes no estimation of the annual cost but authorizes "such sums as may be necessary."

Other science bills introduced in February include: Senator Thomas' S. 525 and Representative Case's H.R. 1815. Both Senator Thomas' bill and Senator Smith's were referred to Taft's Labor and Public Welfare Committee, rather than to the Armed Forces Committee. Senator Thomas was formerly chairman of the Military Affairs Committee which favorably reported science foundation legislation in the 79th Congress.

PR 28 Amended

WASHINGTON, D. C.—The revision of PR 28 on February 13 in no way affected hospitals. The amendment was made chiefly to take care of needs of the army, navy, the Veterans Administration, the U. S. Maritime Commission and the Atomic Energy Commission. In exceptional cases CC ratings may be granted when an item is needed to maintain at current levels essential community utility services, or to provide essential utility services to new housing projects, and when an item is needed in an emergency to eliminate an imminent or existing hazard to the life, health or safety of a large number of people.

National Heart Week

WASHINGTON, D. C.—The American Heart Association sponsored the first National Heart Week, February 9 to 15, as an educational campaign to reduce heart ailments. Some 3,700,000 Americans are victims of heart disease every year, with an equal number afflicted by blood pressure and blood vessel troubles. In 1946, nearly 1000 adults and close to 500 children were treated in local heart clinics affiliated with the Washington Heart Association.

A.Ph.A. Establishes Hospital Division

WASHINGTON, D. C.—The American Pharmaceutical Association and the American Society of Hospital Pharmacists have announced the establishment of a division of hospital pharmacy, according to word February 11 from Dr. Robert P. Fischelis, secretary of A.Ph.A. The division will be under the management of Dr. Fischelis. Gloria Niemeyer, hospital pharmacist, formerly of the University of Michigan Hospital, will act as secretary of the division.

Dr. Fischelis pointed out that the enlargement of existing hospitals and the establishment of new hospitals under recent federal legislation bring sharply into focus the increasing need for standardization and improvement of pharmaceutical service in hospitals. The establishment of the division of hospital pharmacy at A.Ph.A headquarters makes it possible to concentrate attention on these problems in an environment conducive to their solution.

ABOUT PEOPLE

(*Continued From Page* 90.)

Stuart W. Knox is the new manager of Pekin Public Hospital, Pekin, Ill., filling the vacancy created by the resignation of **Mrs. Myrtle Burgener.**

Dr. Dan Morse has been selected as medical director and superintendent of Peoria Municipal Tuberculosis Sanatorium, Peoria, Ill. **Dr. M. Pollak,** who resigned from this position after seventeen years of service, is now tuberculosis control physician in the Illinois State Department of Public Welfare.

Sam O. Gilmer Jr. has assumed the duties of administrator of the Baker-Thompson Memorial Hospital, Inc., Lumberton, N. C., which comprises the combined Baker Sanatorium and the Thompson Memorial Hospital. **R. Lee Britt,** formerly administrator of Baker Sanatorium, is now assistant administrator of the hospital, and **Robert C. Adams,** formerly assistant superintendent of Thompson Memorial, is chief administrative assistant. Mr. Gilmer, who served in the army medical administrative corps, is a graduate of the course in hospital administration of Duke Hospital, Durham, N. C., and was associated with the hospital section of the Duke Endowment prior to his appointment at Lumberton.

Evert E. Moody, a former major in the medical administrative corps, has been named superintendent of Twin Falls County General Hospital, Twin Falls, Ida., filling the vacancy created by

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Patients are More Comfortable ...Require Less Care

The BarcaLoafer is truly a friend in need for overworked nurses and orderlies. It makes possible almost effortless change of position, combined with scientific relaxation of every nerve, every muscle.

The patient is more comfortable, more contented, more "on his own"—and very appreciative of the extra comfort supplied in the BarcaLoafer. It's a wonderful good-will builder with patients and visitors.

One of Canada's Newest Hospitals Has a BarcaLoafer in Every Room

(Name on Request)

Here are some of the benefits:

In addition to the relaxing comfort given convalescents, it has been found especially useful for surgical patients when the treatment calls for getting them out of bed within a few hours after operation—also for cardiac patients.

Let your supply dealer demonstrate the BarcaLoafer comfort-construction to you —and its long life construction. Reasonably priced. Renders a very valuable, a money-saving service.

BARCALO MANUFACTURING CO., BUFFALO 4, N. Y.

Famous also for Barcalo Reclining Wheel Chair

the resignation of **H. C. Jeppesen.** Superintendent Moody began his career in hospital administration as assistant superintendent at Sherman Hospital, Elgin, Ill., in 1930. In 1939 he removed to Green County Hospital, Jefferson, Iowa, and later to Dodge County Hospital, Freemont, Neb., from which he resigned to join the armed forces.

C. Steacy Pickell has been named to succeed **Hal G. Perrin** as business manager of Kansas City General Hospital, Kansas City, Mo. Mr. Pickell, a graduate of the University of Kansas, had some experience in medical administration in the army and was previously secretary of a building and loan association in Kansas City.

Joseph F. Hamrick on March 1 became administrator of Shelby Hospital, Shelby, N. C. He was formerly administrative clerk at Baptist Hospital, Winston-Salem, N. C.

Dr. Louis Benson, formerly assistant medical director of Vermont Sanatorium, Pittsford, Vt., has been made medical director of that institution.

G. S. Drury, who was appointed acting administrator of City-County Hospital, Fort Worth, Tex., following the resignation of **A. C. Sewell,** has been named administrator. Before joining the hospital staff, Mr. Drury, who was educated for the ministry and had been a pastor, served as U. S. Army chaplain for six years and was discharged with the rank of major. His business background includes service as purchasing agent and auditor of oil companies; salesman on exports and imports, and experience as commercial executive with the East Texas Chamber of Commerce.

Department Heads

Roger E. Davis, a former public relations consultant with offices in New York City, has been selected to conduct a program of public relations and fund raising activities for Monmouth Memorial Hospital, Long Branch, N. J. Mr. Davis has been active in the hospital field for ten years. As a member of the staff of the United Hospital Fund of New York he served as a fund raising executive in several campaigns and was radio director of the first Greater New York Fund appeal in 1938. In 1940 he was appointed public relations director of Associated Hospital Service of New York, a post which he held until he enlisted in the army in 1942.

Dorothy Goff, R.N., is the new director of nursing at City-County Hospital, Fort Worth, Tex. A graduate of the University of Texas, Miss Goff took her nurse's training at John Sealy Hospital, Galveston, Tex. She served as director of nursing at Brackenridge Hospital, Austin, Tex., before entering the army nurse corps in which she served for thirty months.

Charles L. Freeman has been appointed to the newly created post of executive secretary and public relations director at Rockford Memorial Hospital, Rockford, Ill. Mr. Freeman was formerly Illinois representative for the National Foundation for Infantile Paralysis.

Miscellaneous

Homer Folks, who served fifty-four years as secretary of the State Charities Aid Association, New York City, has retired. During his long career in public health and social service, Mr. Folks made notable contributions in pioneering activities in organized movements for the improvement of public institutions, for the care of children, for public relief, for the prevention of tuberculosis and for the promotion of preventive medicine and mental hygiene. Succeeding Mr. Folks is **Rowland Burnstan,** economist, educator and executive, who since 1943 has been president of the Lawrance Aeronautical Corporation. Mr. Burnstan has also lectured on economics at the University of Chicago and at one time was professor of economics at Carleton College.

Charles S. Billings has been employed by the Kansas State Hospital Association as executive secretary.

Francis A. Walker succeeds **Donald Murphy,** resigned, as managing director of the Hospital Service Corporation of Decatur, Ill. Mr. Walker has been associated with the Decatur plan since its organization.

Deaths

Charles B. Goodspeed, for many years president of the board of managers of Presbyterian Hospital, Chicago, died recently after a long illness.

THE BOOKSHELF

HOSPITALS — INTEGRATED DESIGN. *By Isadore Rosenfield. New York: Reinhold Publishing Corporation,* 1947. *Pp.* 275. $10.75.

Here, indeed, is a book to generate real enthusiasm among hospital administrators, architects and consultants. Mr. Rosenfield has fashioned an important volume from a series of lectures given in 1944 under the auspices of the New York City Department of Public Works and the New York chapter of the American Institute of Architects.

Chapter I is devoted to facts covering the need for hospital facilities. Mr. Rosenfield's discussion of hospital economics and the rôle of voluntary hospitals in caring for indigents does not fit the actual facts. He fails entirely to recognize the overwhelming burden placed upon voluntary hospitals in their efforts to care for indigents at rates of payment from governmental units so far below cost as to endanger the financial stability of many voluntary hospitals.

The statements by Mr. Rosenfield and discussion by Dr. Roberts are so far from the average facts that this section of an otherwise splendid book might better have been omitted.

The chapter on comprehensive planning should be read by anyone having responsibility in hospital planning. The author rightfully points out that too many hospital boards plan on a hand to mouth basis and too often spend the funds entrusted to them in a penny-wise and pound-foolish manner. The fallacy of building two or more small hospitals in an area where one medium sized or large institution could give a higher standard of care at a lower cost per patient day is forcefully pointed out. The author calls attention to the foolishness of raising funds before a careful study of community and area hospital needs is made. Mr. Rosenfield states, "The comprehensive planner's position is that no board of trustees acts with wisdom if it goes out to raise funds before it knows what those funds can cover, and the only way to find out is through the preparation of a comprehensive plan.

"In this manner, the first increment of construction will not become a stumbling block to the second and future increments but will become one of a series of logical steps."

The chapter on general considerations and functional elements covers such important points as site, orientation, selection of architect, budgeting, preliminary drawings, circulation of traffic, construction systems, esthetics and many others. The following statement should be memorized by everyone in the field.

"The friends or relatives of patients on approaching the hospital should not be intimidated with its officious monumentality, but should be made to feel that their friends or dear ones are in the presence of kindliness, consideration and scientific certainty."

The chapters on the nursing units and other professional departments point out

HOSPITAL CAMPAIGN GOES OVER TOP!

Reports Bring Total To County Record Of $1,048,277

Still More Subscriptions Expected At Extra Report Meeting Next Week; Workers Celebrate At Victory Dinner By Turning In $169,400 to Surpass Goal

Rolling up $169,400 at the "victory dinner," the $1,000,000 Altoona Hospital Expansion Campaign went over the top last night at the Penn Alto hotel.

The grand total is now $1,048,277, but the campaign will not be concluded until next Thursday noon when an extra report meeting will be held to round up subscriptions still pending.

The enthusiastic meeting, marked by almost continuous ball ringing for divisions exceeding their quotas, afforded the achievement of the biggest capital fund campaign in Blair county's 100-year history.

Realtors Hear Address On Building Loans

Erie R. R. Income

Altoona Tribune

WEATHER: Rain and Mild

Vol. 91—No. 20 Saturday, January 25, 1947 Five Cents

May Pleads Innocent To Fraud Charge

Former Chairman Of House Military Affairs Committee Goes to Trial March 19

Coal Miners Denied State Compensation

Soviet-British Pact Needs Revision, Says Premier Stalin

Premier Admits Pact Has Not Been Repudiated But Declares It Must Be Strengthened

By GLENN WILLIAMS

U. S. Steel and CIO Agree to Contract

Present Contract Ends Feb. 15; Union Presents Point Program

"Liberal Policy" Landlord

HOME EDITION

The Circulation of the Altoona Mirror Yesterday Was— 32,002

VOL. 62—NO. 100 PHONE 7171

Altoona Mirror.

ALTOONA, PA., SATURDAY EVENING, JANUARY 25, 1947.

WEATHER: CLOUDY

Altoona is known as a city of churches. It can become famous as a city of church goers. Go to church tomorrow.

TWELVE PAGES—PRICE FOUR CENTS

HOSPITAL DRIVE TOPS MILLION MARK

MORE COMING FOR CLEANUP, LEADERS SAY

Victory Dinner Reports Excess of $48,277 Over Campaign's Goal.

Cancer Bank Larceny Nets Campaign $10

DIST. ATTORNEY SEEKS INQUEST

GENERAL VIEW OF CROWD AT VICTORIOUS, "OVER-THE-TOP" DINNER

GEN. MARSHALL WILL ATTEND BIG 4 PARLEY

New Secretary of State Going to Moscow Council Session on March 10.

By E. E. BRADFORD, Staff Correspondent

LABOR BILL GIVEN COOL RECEPTION

Proposed Legislation to Regulate Union Issue Meets With Opposition.

clearly how proper design based on functional duties can elevate standards of patient care and still reduce personnel hours and costs.

The material on service departments is superb and shows that the author is indeed a real student of hospital needs.

Material on outpatient departments is well organized. The author predicts a great increase in outpatient department service in general and special hospitals. He discusses the advantages of combining group practice clinics for private patients with outpatient departments for medical indigents as an integral service of hospitals.

The chapters on daylighting and artificial illumination are of outstanding value.

Since most hospital administrators and many architects are not sufficiently familiar with the mechanical equipment of hospitals, the chapter on the mechanical plant will be particularly welcome. This chapter could have been strengthened by the inclusion of facts on boiler room controls and instruments. The importance of CO_2 meters, stack temperature recorders and automatic mechanical draft controls in burning coal, oil or gas at 70 to 80 per cent efficiency should have been emphasized.

The chapter on construction presents the case for modular coordination and space planning in an excellent manner. In discussing construction costs, the author drives home many important points which many planners ignore. He particularly warns against penny pinching through improper space provision and the use of materials and equipment unsuited to the tough requirements of hospital usage. Cheap materials and equipment and poor design will always result in high operating and maintenance costs.

Mr. Rosenfield's splendid book makes a great contribution to the cause of better hospitals.—Everett W. Jones.

Group Feeding. *By Clifford Allen Kaiser. New York and London: McGraw Hill Book Company, Inc.,* 1945. *Second Edition.* Pp. 490. $5.

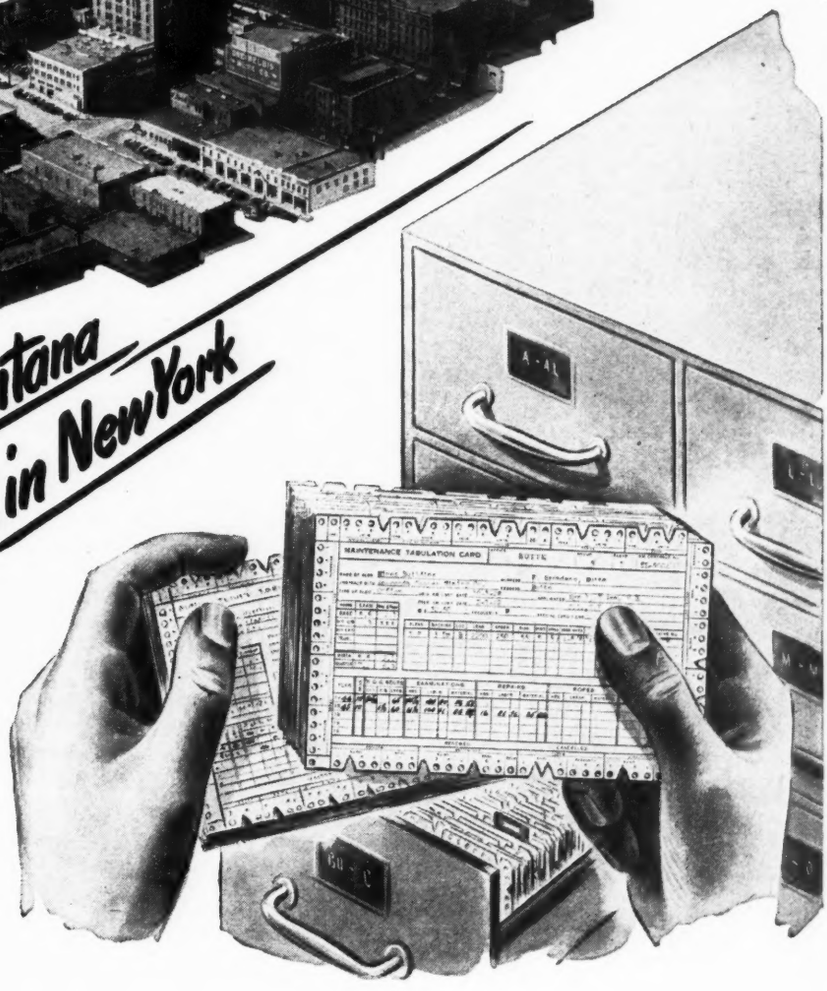
This second edition of a book first published in 1940 primarily for use in Civilian Conservation Corps camps, according to the preface, is offered because of the continuing demand for copies of the first edition now out of print.

There is no clue on the jacket or elsewhere as to the author's qualifications, but he has assembled with fair success a rather elaborate collection of data from federal and state sources, including presumably the Quartermaster Corps and other public and private organizations. On the whole, the author presents his material with reasonable clarity and accuracy. But we find little evidence of a practical application of the science of nutrition among the recipes for, apparently, the author favors the soak-cook-and-drain school of cookery when it comes to green vegetables. And there is no indication under soups or elsewhere that the liquid in which these vegetables are cooked or canned is to be drained into the soup stock instead of the sink.

The hunt-and-find method is used in the recipes where, except in rare instances, none of the ingredients is listed in the order of their use. Quantities to serve five, 10, 20, 50 and 100 persons are given in generous amounts for healthy, outdoor, masculine appetites, but there is no clue as to the size of each serving. Expense is apparently no object for butter is used even for fried onions and parsnip fritters, yet earlier, under the chapter on nutrition, the author learnedly declaims that butter should not be used for frying since this "destroys the Vitamin A."

We would suggest that those concerned with large group feeding operations might fare better with the aid of books prepared by qualified dietitians, such as those by Wood and West and the cookbooks now authorized for use by the army and navy.—Mary P. Huddleson.

Photo courtesy Northern Pacific Railway Company.



this is Butte in Montana
this is Butte, Mont. in New York

In Butte, Montana, we are responsible for the complete and constant care of 33 Otis elevators.

At Otis Headquarters in New York, each of these elevators has a card on which its service record is kept up-to-date.

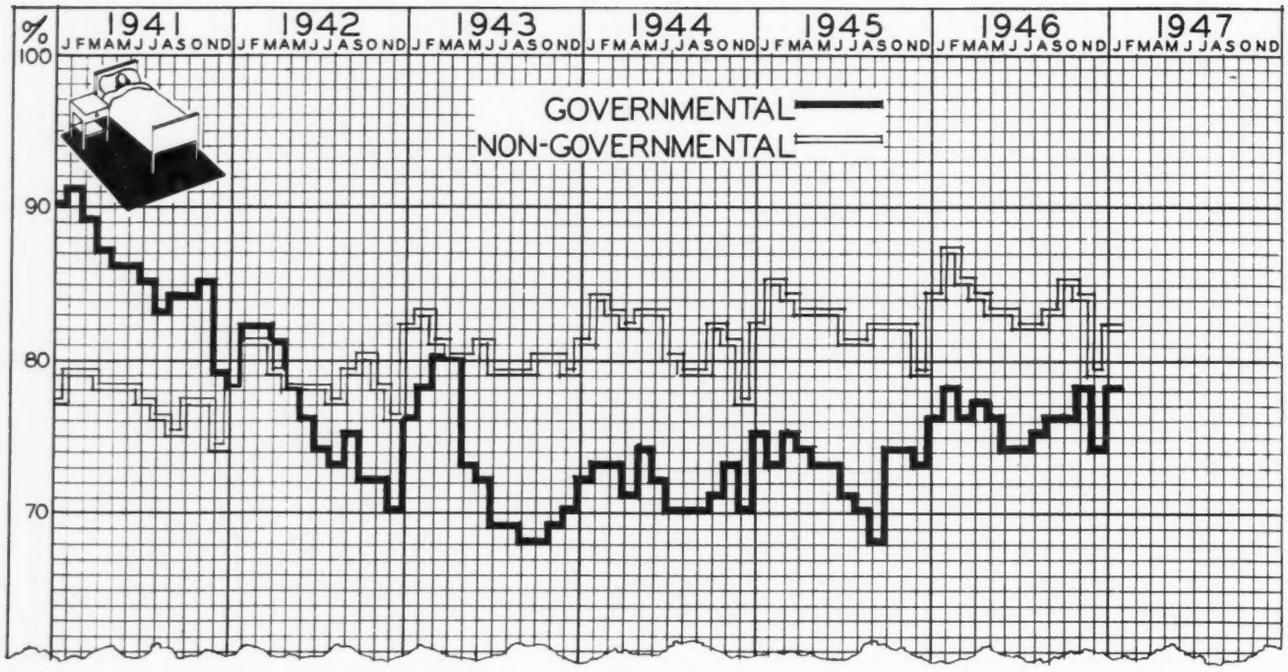
In Butte, local Otis-trained maintenance men inspect the Otis-maintained elevators—regularly cleaning, lubricating, adjusting and repairing them when required.

In New York, Otis-trained analysts regularly study the service records of the Butte elevators. Averaging, comparing and interpreting them against the service records of 30,000 other elevators. Exceptional records are investigated and the knowledge gained is transmitted to Otis maintenance men in 245 local offices.

There is no other maintenance service like Otis Maintenance—anywhere. It can be obtained by 'phoning your local Otis office.

Otis ELEVATOR COMPANY
OFFICES IN ALL PRINCIPAL CITIES

Occupancy of Voluntary Hospitals Rises



After the customary December dip, occupancy of nongovernmental hospitals reporting to the Occupancy Chart climbed back to 82.4 per cent of capacity in January. This is slightly less than the occupancy reported in January a year ago. Governmental hospitals reported 77.9 per cent of beds filled—peak load for the last two years.

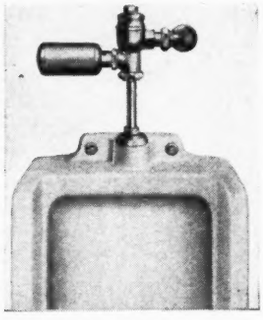
Hospital construction projects reported for the second period of the year totaled $35,376,564, nearly twice the total for the same period last year. The first two periods totaled $94,052,758 as against $37,941,302 in 1946. In the latest period, 38 building projects were reported with detailed costs amounting to $16,154,108. Of these, 21 were new hospitals costing $11,427,000; 15 were additions totaling $4,077,108, and one was a nurses' home listed at $150,000.

What's New for Hospitals

MARCH 1947 SUPPLEMENT TO THE MODERN HOSPITAL

Electrically Operated Flushometers

More hygienic conditions in toilet rooms for personnel as well as the public are possible through the new automatically flushing urinal flushometers



developed by Sloan Valve Company. Eliminating hand operation, the new flushing system is operated by a remote control electric time-clock mechanism which accurately controls the time between flushes. It is designed for day and night operation, flushing the urinal once every five minutes throughout the day and once each hour at night.

The system can be applied on old or new installations and results in a great saving of water while at the same time keeping the urinal clean and sanitary. It is designed to operate on 60 cycle 110 volt alternating current. **Sloan Valve Co., Dept. MH, 4100 W. Lake St., Chicago 24. (Key No. 3424)**

Obstetrical Forceps

Two improved obstetrical forceps have been produced by J. Sklar Manufacturing Company. The Bailey-Williamson Obstetrical Forceps offers an improved instrument designed to minimize the hazards of most types of forceps delivery. The instrument features an improved head curve, wider opening at the tips and longer shank.

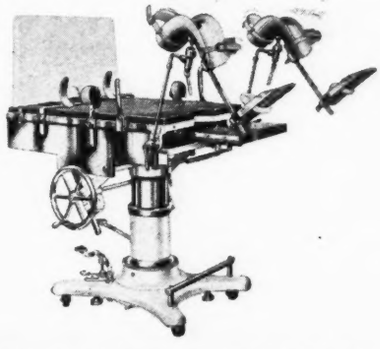
A forceps that is adaptable to both head and pelvic axis at the same time, permitting a cephalic application without disturbing the normal relation of the head to the pelvis and not interfering with normal mechanism of labor, is offered in the Barton Obstetric Forceps. The forceps differs from the usual type in that the blades join the shanks at an angle. Both instruments are stainless steel. **J. Sklar Mfg. Co., Dept. MH., 38-04 Woodside Ave., Long Island City 4, N. Y. (Key No. 3455)**

Non-Toxic Roach Killer

Arfax PCH Insect Killer is a non-toxic exterminating powder possessing toxic affinity for cold-blooded insects including roaches, silverfish, ants, waterbugs, centipedes and similar nuisances. Contact with the powder, which is non-poisonous and harmless to humans and warm-blooded animals, quickly induces paralysis, resulting in death to the insect. Any dust gun can be used to blow the product where needed. The powder is stable, with long lasting residual properties, and is available in 1, 5 and 25 pound containers. **Fairfield Laboratories, Inc., Dept. MH, Plainfield, N. J. (Key No. 3440)**

Improved O.B. Bed-Table

The new Cincinnati O.B. Bed-Table combines the advantages of one piece and two piece beds. With the foot end extended a full length, roomy, operating table type delivery unit is available which raises, lowers, revolves and tilts in either direction. The single, con-



venient foot lever controls both elevation and revolution of the top. A large hand wheel tilts the top speedily and effortlessly.

When not wanted the foot section telescopes completely within the head section, without resort to gears or ratchets, leaving no projecting bars or supports. A newly developed type of suspension gives the leg rest unusual stability when extended for use.

A new brake system lifts the bed completely off its wheels while it remains solidly in place on the floor. Standard equipment includes foam rubber cushions and complete accessories. **The Max Wocher & Son Co., Dept. MH, 609 College St., Cincinnati 2, Ohio. (Key No. 3468)**

Chrome and Leatherette Chairs

Two new arm chairs in chrome and leatherette have been developed by Ard

Manufacturing Company. While it is modernistic in appearance, No. HA4, illustrated, provides restful comfort with proper posture support, form-fitting seat 19 inches wide and 19 inches deep, and curved back 12 inches high. The upholstered arm provides added relaxation with arm support. The strong framework is of triple-plated chrome tubing and it is upholstered in leatherette in a choice of colors including Moorish brown, Moorish red and plain red.

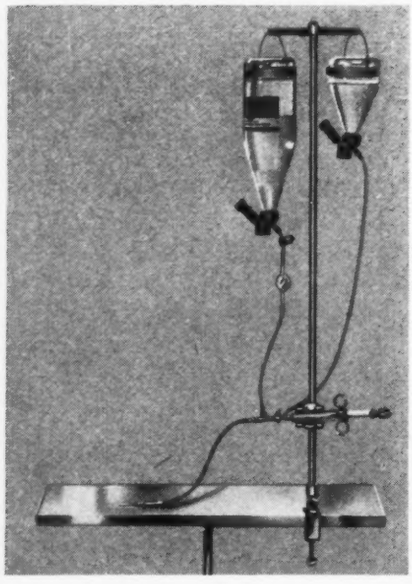
The second chair, No. SA106C, offers the same qualities of comfort, modern design and durability without upholstered arms. It is built on the streamlined principle with S-curved leg. **Ard Mfg. Co., Dept. MH, P. O. Box 442, Evansville 3, Ind. (Key No. 3492)**

Orange Juice Concentrate

Minute-Maid Quick-Frozen Orange Juice Concentrate is prepared by the Thermo-Vac process involving the use of very high vacuum. The water vapor of the juice is sublimated from ice without melting the ice and the evaporated juice thus retains the flavor and nutritive values of fresh juice. No defrosting is required and the concentrate mixes readily with cold water. This new product is designed to keep its flavor for many hours after mixing. **Vacuum Foods Corp., Dept. MH, Park Square Bldg., Boston 16, Mass. (Key No. 3436)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 252

Johnson Pentothal Sodium Outfit



A simple, complete, closed method for the administration of Pentothal Sodium by syringe, drip or combination of syringe and drip technics is offered in the Johnson Pentothal Sodium Administration Outfit. Where a number of intravenous administrations are scheduled for a single day it is necessary only to change the short length of tubing, glass observation tube and needle proximal to drip valve to be ready for use on each new patient.

The support of plasma or any other solution to be administered in another vein or by puncture in tubing above observation tube is provided for by four hanger connections, thus eliminating the need for an additional floor standard.

The arm board table to which the unit is attached offers a flat arm rest regardless of the position of the operating table. It is adjustable in height from 24 to 39½ inches, the top is made of stainless steel measuring 10 inches wide by 24 inches long and the whole is mounted on a broad tripod base. **A. S. Aloe Co., Dept. MH, 1831 Olive St., St. Louis 3, Mo. (Key No. 3437)**

Wall Type Radio

The American Built-In Wall Type Radio is a new unit which would be suitable for installation in private rooms in the hospital or in the nurses' home. It is modern in design and available in various colors to match decorating schemes. A timing device with automatic switch can be set to turn the radio on and off and a duplex light plug in the unit can be used for other electrical appliances in the room. **American Communications Corp., Dept. MH, 306 Broadway, New York. (Key No. 3458)**

Casco Moist Heat Pads

After six years of research and testing, Casco has produced two new electric pads said to be the first for the application of moist heat. The first of these pads is an electric fomentation heating pad for use where wet-dry heat is indicated. Made with a 100% wetproof vulcanized castex body, the wet-dry pad is equipped with an illuminated nite-lite switch with 30 fixed heats to provide constant temperatures as required by the patient.

The smaller sinus and muscle pad is designed for easy application to the forehead, throat, chin and around the joints. Through two pre-set heats, the pad gives low heat on one side and high on the other, either dry or wet.

Both moist heat pads are equipped with the special Casco water reservoir made of cellulose material which retains moisture from 10 to 12 hours with heat. A heavy duty hospital sheeting slipcover serves to protect the wetproof pad and the patient. It has two tie-tapes for easy adjustment to body or limbs. The larger electric fomentation pad also has two detachable flannel applicators for use with

ointments. Both the slipcover and applicators are washable. **Casco Products Corp., Dept. MH, Bridgeport 2, Conn. (Key No. 3371)**

Fenwal Tube and Needle Sets

The Fenwal Tube and Needle Set for parenteral therapy procedure offers several practical innovations. The expendable tubing fabricated of transparent plastic can be sterilized once in conjunction with the unit and discarded after use, eliminating time and trouble of cleaning. It is supplied on a 12 inch reel carrying 3000 feet of tubing and the chrome plated, metallic reel stand is equipped with a cutter attachment permitting instant preparation of any length required.

The Fenwal Clamp provides for instant control of any desired fixed-drip range of flow, the air vent tube with integral drip requires only one connection and the Fenwal needles are especially designed for greater safety, ease of cleaning and efficiency. The Pyrex Brand adapter is designed for using Fenwal expendable tubing with standard needles and a tubing adapter for use with commercially prepared solution containers and non-Fenwal tube and needle sets is also available. **Macalaster Bicknell Co., Dept. MH, 243 Broadway, Cambridge 39, Mass. (Key No. 3475)**

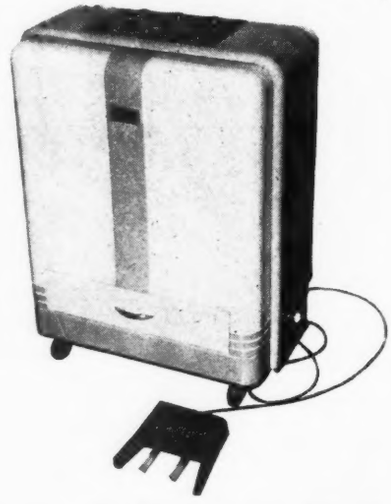
Automatic Fire Detection

Vigilarm, a new, improved fire detection system, is designed to discover fire, give warning and summon the fire department. Consisting of a continuous length of fine copper tubing installed along the ceiling, the system permits constant electrical supervision and is designed to eliminate the possibility of corrosion, rupture, breakage or removal.

Operating on the rate-of-rise principle, the tubing instantly detects and reports the abnormal heat that is present in every fire, however small, and if the fire is not immediately extinguished, the detector unit sends out a fire signal over the municipal fire alarm system to the fire department. **The Gamewell Co., Dept. MH, Newton Upper Falls, Mass. (Key No. 3413)**

Hanovia Electro-Surgical Knife

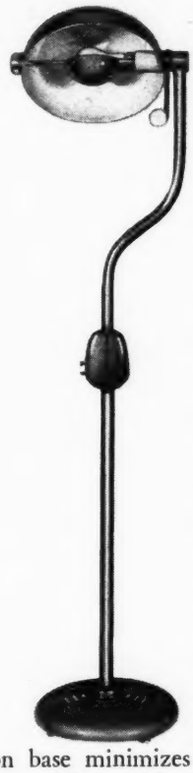
Years of research, experiment and development have resulted in the new Hanovia Electro-Surgical Knife announced as a significant contribution to bloodless surgery. An outstanding feature of the new unit is the employment of two separate oscillator circuits which permit cutting or coagulating to be done alone or simultaneously. The knife is also designed to operate submerged in



liquids. **Hanovia Chemical & Mfg. Co., Dept. MH, Newark 5, N. J. (Key No. 3421)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 252

Hospital Floor Lamp



Of particular interest and importance to the hospital is the fact that the new Hill-Rom floor lamp has been tested and approved by Underwriters' Laboratories, thus guaranteeing its safety. In addition the lamp is attractive and practical. It is so designed that the shade can be rotated simply and easily in a 360 degree arc without twisting or moving the wires, thus ensuring proper light for all needs in the patient's room with complete safety and comfort.

The heavy cast iron base minimizes the possibility of tipping. The seamless steel upright tubing revolves in the base within an oilite bushing, thus permitting free turning and the shade is made of spun and stamped steel. The lamp is designed for convenient, economical repairing when needed. **Hill-Rom Company, Inc., Dept. MH, Batesville, Ind. (Key No. 3459)**

Oxygen Therapy Equipment

The Liquid Carbonic Corporation, manufacturer of compressed gases, now has a complete line of oxygen therapy equipment. Designed and manufactured to the company's high standard of performance and dependability, the line includes humidifier outfits, penicillator units, oxygen regulators, portable oxygen outfits, oxygen tents, accessories and supplies. **Liquid Carbonic Corp., Dept. MH, 3100 S. Kedzie Ave., Chicago 23. (Key No. 3454)**

Flow E-Z Breast Pump

The "Flow E-Z" Breast Pump is scientifically designed to operate without bother or discomfort to the patient. It employs no electricity, water supply or rubber bulbs and the operator can regulate the necessary amount of vacuum for the correct flow of milk. The gentle action prevents bruising and is not destructive in cases of caked breasts or cracked nipples. The pump is designed to give years of uninterrupted use. The unit comes complete with pump, special tubing, glass shield, bottle, cork and metal adapters. **United Surgical Supplies Co., Dept. MH, 160 E. 56th St., New York 22. (Key No. 3452)**

RCA Intercom System

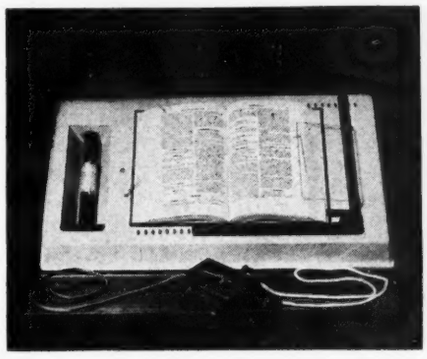
A new two station intercommunication system with compact speaker stations as small as an ordinary desk clock has been announced. Newly designed and engineered, the system provides separate units for the amplifier and the speaker station, permitting off-the-desk location of the amplifier and reducing speaker station size to a minimum.

The new system is especially designed for communication between executive and secretary, doctor and receptionist or other individuals where frequent communication is desired. It is easily installed and plugs into any 110 volt AC or DC outlet. If desired, additional stations up to five can be connected to the amplifier. **Radio Corporation of America, RCA Victor Div., Dept. MH, Camden, N. J. (Key No. 3444)**

Automatic Page Turner

An electro-mechanical page turner for use with either books or magazines has been developed for patients unable to use their hands for this purpose. Molded from plastic-impregnated fabric to ensure long wear, the device is strong and durable, light in weight and the attractive surface finish will not mar with rough usage.

The device is simple in operation and can be plugged into any ordinary electrical outlet. A feather touch switch hung around the neck of the patient is



depressed by simply lowering the chin, thus activating the motor turning the page. A special adaptation has been developed for patients confined in artificial respiration devices. **General Textile Mills, Inc., Dept. MH, 450 Seventh Ave., New York 1. (Key No. 3466)**

PHARMACEUTICALS

Amino-Concemin

Amino-Concemin, a nutrient tonic in a wine-flavored base, is designed to speed convalescence. The product contains the established B vitamins, the whole B complex from liver, rice bran and yeast, peptonized iron and 15% of protein hydrolysate, an enzymatic yeast hydrolysate that most closely approximates the amino acid and polypeptide content of meat.

Amino-Concemin supplies the essential and supplementary B complex factors; hematinic; tonic; dietary supplement; stimulates hemoglobin formation and facilitates vitamin B assimilation by enzymatic action. It is supplied in pint and gallon bottles. **Wm. S. Merrell Company, Dept. MH, Cincinnati 15, Ohio (Key No. 3381)**

Protein-Vitamin Preparation

Hydrolysin is a therapeutic aid in protein depletion, as well as a dietary supplement in many conditions requiring high nitrogen intake. It contains Protein Hydrolysate, 60%, providing ample amounts of all the essential amino acids; Carbohydrate, 30%, and Starch, 10%, together with therapeutic amounts of all the known and unknown B Complex factors. It is supplied in bottles containing 250 Grams. **William H. Rorer, Inc., Dept. MH, Philadelphia 6, Pa. (Key No. 3396)**

Estrogenic Hormone

The potent estrogen Progynon-B, Schering's alpha-estradiol benzoate, is available for the first time in economical 10 cc. multiple dose vials. Each cc. of the crystalline pure follicular hormone preparation contains 0.166 mg. alpha-estradiol benzoate, having a potency of 1000 rat units, equivalent to 10,000 international units. The vials are packaged singly and in multiples of six. **Schering Corporation, Dept. MH, Bloomfield, N. J. (Key No. 3397)**

High Potency Protein Hydrolysate

A new fortified protein hydrolysate preparation, Aminoprod, supplies all the essential, as well as certain of the non-essential amino acids, and has a protein content of 67%. It contains 90% yeast (protein) hydrolysate, together with vitamins A, D, C, B_1, B_2, Niacinamide and minerals; iron, calcium and phosphorus. Aminoprod is supplied in 8-ounce and 1-pound bottles. **Drug Products Co., Inc., Dept. MH, Passaic, N. J. (Key No. 3374)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 252

RECENT CATALOGS AND BOOKLETS

• New catalogs on **"Food Conveyors"** and **"Metal Cabinets and Case Work"** illustrate and describe equipment especially designed for hospitals. S. Blickman, Inc., Weehawken, N. J. **(Key No. 3344)**

• **"How to Fight Fires and Protect Property"** explains technics in fighting fires with carbon dioxide and other type fire extinguishers. Randolph Laboratories, 8 E. Kinzie St., Chicago 11, Ill. **(Key No 3352)**

• New **Recipes Utilizing "Art's Brand" Corned Beef Hash** have been created by Louis P. DeGouy, internationally famous chef. The recipes, printed on individual index cards, fit the customary recipe file box and are available free to persons interested in the preparation and purchase of food. **Arthur L. Peirson & Co., Dept. MH, 342 Madison Ave., New York 17, N. Y. (Key No. 3306)**

• Holler's Concentrated Beverages, Miami, Fla., are distributing **"All Purpose Imitation Flavors Recipes." (Key No. 3351)**

TO HELP YOU get information quickly on new products we have provided this convenient Readers' Service Form. Check the numbers of interest to you and mail the coupon to the address given below. If you wish other product information just list the items and we shall make every effort to supply it.

Bessie Covert,
Editor, "What's New for Hospitals"

- ☐ 3296 "Water Supply and Booster Systems for Buildings"
- ☐ 3300 "Floor Treatments (Book B)"
- ☐ 3306 "Art's Brand" Corned Beef Hash Recipes
- ☐ 3319 "Amcoin All-Glass Interior Juice Fountains"
- ☐ 3323 "Steam-Chef Catalog"
- ☐ 3337 "Get Acquainted With Your Fire Extinguisher"
- ☐ 3339 "Canned Foods Recipes for Serving Fifty"
- ☐ 3344 "Food Conveyors" and "Metal Cabinets and Case Work"
- ☐ 3351 "Imitation Flavors Recipes"
- ☐ 3352 "How to Fight Fires and Protect Property"
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- ☐ 3374 High Potency Protein Hydrolysate
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- ☐ 3396 Protein-Vitamin Preparation
- ☐ 3397 Estrogenic Hormone
- ☐ 3413 Automatic Fire Detection
- ☐ 3421 Hanovia Electro-Surgical Knife
- ☐ 3424 Electrically Operated Flushometers
- ☐ 3436 Orange Juice Concentrate
- ☐ 3437 Johnson Pentothal Sodium Outfit
- ☐ 3440 Non-Toxic Roach Killer
- ☐ 3444 RCA Intercom System
- ☐ 3452 Flow E-Z Breast Pump
- ☐ 3454 Oxygen Therapy Equipment
- ☐ 3455 Obstetrical Forceps
- ☐ 3458 Wall Type Radio
- ☐ 3459 Hospital Floor Lamp
- ☐ 3466 Automatic Page Turner
- ☐ 3468 Improved O.B. Bed-Table
- ☐ 3475 Fenwal Tube and Needle Sets
- ☐ 3492 Chrome and Leatherette Chairs

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MAIL TO Readers' Service Dept., The Modern Hospital Publishing Co., Inc.
919 N. Michigan Ave., Chicago 11, Ill.

• **"Amcoin All-Glass Interior Juice Fountains"** are described and illustrated in a new four-page folder, D46. Sizes and capacities are given, as well as a cutaway view of the interior with a detailed explanation of operation. **Amcoin Corp., Dept. MH, Buffalo 9, N. Y. (Key No. 3319)**

• The new **"Steam-Chef Catalog"** contains illustrations and descriptions of various Steam-Chef models. It also has a section on the selection of specific equipment for a given installation and other items of interest to persons preparing food in quantity. **The Cleveland Range Co., Dept. MH, 3333 Lakeside Ave., Cleveland 14, Ohio (Key No. 3323)**

• A new booklet on **"Canned Foods Recipes for Serving Fifty"** has just been issued by National Canners Association. 1739 H St., N.W., Washington, D. C. **(Key No. 3339)**

• A new illustrated specification book on **"Floor Treatments"** (Book "B") has sections on integral hardeners, chemical hardeners, concrete dye, surface coatings and wood floor preservatives. Descriptions of the products are given on the reverse side of the specification sheets. **Truscon Laboratories, Inc., Dept. MH, Caniff and G. T. R. R., Detroit 11, Mich. (Key No. 3300)**

• The booklet on **"Get Acquainted With Your Fire Extinguisher"** discusses the care of fire extinguishers. The General Detroit Corp., 2272 E. Jefferson Ave., Detroit 7, Mich. **(Key No. 3337)**

• Bulletin 1500 on **"Water Supply and Booster Systems for Buildings"** gives data on determining head and capacity requirements, selecting the proper system and pumping equipment, typical piping and pump installations and approximate dimensions for layout purposes. **Yeomens Bros. Co., Dept. MH, 1462 N. Dayton St., Chicago 22, Ill. (Key No. 3296)**

Manufacturers' Plant News

Service to the southern states on the pharmaceuticals, biologicals and biochemicals manufactured by the **National Drug Co.,** 4663 Stenton Ave., Philadelphia, has been enhanced through the opening of a branch office and warehouse at 15 Baker St., N. E., Atlanta 3, Ga. **(Key No. 3405)**

Juice Industries, Inc., is the new corporate name of **Citrus Concentrates, Inc.,** Dunedin, Florida. The line of citrus fruit products produced by this company will continue to appear under the trade name "Sunfilled." **(Key No. 3409)**

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